Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 4, 2:30 AM BOOTH Oct. 2006 ANNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center 8. Date of Birth (Month, Dev. Year) 8/25/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 217-36-2852 80 Yrs. Poland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director MD. Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 109 Gunnison Drive 21001 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? other traumatic event, the Madical Examiner ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 ☐ Divorced Year or Dates: 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic avogas. Milek Katrina Philip Dutchak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Heckmann/Friend 105 Gunnison Drive Aberdeen, Md. 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 10/6/2006 Hampstead, Maryland 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 10 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available for to completion of cause of death?

1 Yes 2 / J 1 ☐ Yes 2010 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 10 2 ER/Outpatient 3 DOA 27. Mayner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 TYes 2 No 2 Accident investigation Director: , 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours at To the Funerel D completely filled i Medical Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

06-07364 Evelvn Bender

## Please Type or Print in Black Indelible Ink Manyland / Department of Health and Mental Hygiene

Evelyn bender	1- For State  Certificate of Death  Reg. No.
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
Medical Examiner	Evelyn Bender September 30, 2006
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Frederick Memorial Hospital  Frederick  Frederick
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	220-01-1235   1 M 2 K   84 Yrs.   Months Days Hours Min. September 20, 19 2 Gountry and
è	Usual Residence of Decedent  10a State
tow any	Maryland Frederick Frederock 1 X Yes 2 No
the Maryland a or 28a-f show uffied at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once. al Director	30 N. Place 21701 USA
r death with or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 1 Never Married 2 Married 3 Ma
ter dea	1 Yes 2 No 3 K Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White
atural"	I or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
5-0036 ed within 72 hour dygrene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
d within d within the ther the Med	12 tabric cutter CIOTHING  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
215 be file antal Hy rked o ent, th	Charles Moberly, Jr. Grace Wisner
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Austin Bender – son  606 Trail Avenue, Frederick, Maryland 21701
e, M l and 2 Health 2 item 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
nore ages 1 ant of F other	1 & Burial 2 Cremation 3 Removal from State crematory or other place)  4 Departure 5 Other Specify Mt. Olivet Cemetery 10-5-2006 Frederick, Maryland
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702
	Maryland 1621 Opossumtown Pike, Frederick, Maryland
Physician // // // // // // // // // // // // //	failure. List only one cause on each line  Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  Back injuries of lication by retensive attended at the condition resulting in death)  Due to (or as a consequence of): disease
	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of).
mine	cause. Enter Underlying Cause (Disease or injury that initiated
60, tte be executed  yysician and e burial - transit Aedical Examine	events resulting in death) Last  Due to (or as a consequence of):  d
60, tte be executed hysician and e burial - transit	☐ AMENDED #23a,27,28a-f, perME, g863 1/8/07 TT
760, icate be physicithe buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
b. Box 6876 the death certificat by the attending phy ched for use as the Physician/M	past 12 months?  4 Pregnant at time of 5 Other (Specify)
Box ne death the atte	1 Yes 2 V No 9 Unknown 9 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death  al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach settification: To Be Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
Records, The law require ficate has been sig. page 2 should be Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
ecol ne law te has i ge 2 sh	autopsy prior to completion of cause of performed? death?  1 ✓ Yes 2 N 1 ✓ Yes 2 No
tal Rection: The certificate ector, page	25. Was case referred to medical 26.Place of Death (Check only one)
f Vita Physicia er this ce ral direc	examiner? 1 Ves 2 No  Hospital 1 Inpatient 2 ER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other:
n of ding Ph	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending  28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred  Subject passenger of vehicle going
visior or Atteno frer death Director: in by the	2 M Accident Investigation 9/28/2005 13:45 pm   Nover speed bump 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street an Number or Rural Route Number, City
Division c spital or Attending tours after death nours after death filled in by the fun Certification	Suicide 6 Could not be determined (Specify) roadway or Town, State) Fairview between College arkway & Macer Frederick, MD
흥골필송 등	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the complete	; and manner stated  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	O.C.M.E. October 1, 2006
	30. Name and address of person who completed cause of death (Item 23a)
Contraction	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Monthly, Yar) 2006 32 Assistar's Signature
State Registrar	

#### Please Type or Print in Black Indelible Ink

06-07487 State of Maryland / Department of Health and Mental Hygiene Carlo Peter Bona Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 4, 2006 1505 hrs Medical Examine Carlo Bona 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) **Baltimore** 2108 N. Calvert Street If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Funeral oreign Months Davs Hours Director Country)Maryland 1X M July 4 1956 220-70-2426 50 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location any 1 Yes 2 X No or 28a-f show Anne Arundel Crownsville MD with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21032 1145 Severn View Drive USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2XX No Yes 1 Yes 2 X No specify. Specify White If Yes. Give Year nours after Widowed Divorced "natural", ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) nit Pages I and 2 should be filed within 72 artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "ry or other traumatic event, the Medical.) 27 is marked other than ' Baltimore, MD 21215-0036 Construction 12 Iron Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlo Peter Bona Felicia Majchrzak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1145 Severn View Drive, Crownsville, MD 21032 Carla J. Stefanelli (Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State permit Pages Department of Important: Metro Crematory Baltimore, MD Other Specify: Donation 5 22. Name and Address of Facility
Hardesty Funeral Home, P.A Signature of Funeral Servine Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear MD Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Cirrhosis of liver Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and sician/Medical X UNPENDED attending physician a **AMENDED** item#23a,27,perME,g860, 10/19/06 TT The law requires that the death certificate be Box 68760, 23d Date of delivery IE EEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year Month Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Ph Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Vunknown ģ Completed 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 2 No ✓ Yes 2 No 1 🗸 Yes After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene DOA FR/Outpatient 3 1 🗸 Yes 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending the Accident 28f Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 5, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) 0 2006 State

Registrar

			For State Registrar	State of Maryla		epartment of F Certificate of			giene Reg. No.	006	32505
	Physici	an	1. Decedent's Name (First, Middle, La	Brinsfield	ı			2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Donna V.		1			Octob		,2006	0615 M
	Examin	er	4a. Facility Name (If not institution, giv	1 Hospital			Laston			ounty of Death albot	
	Funeral		5. Social Security Number 6. 5		s. last birthe	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			place (State or Foreign
	Director		. 216-64-8755	1□M 21xF 5(	) Yr	s. Months Days	Hours Min.	8. Date of Bir (Month, Da Nov . 23	1955	Mar	place (State or Foreign intry) y land
	pu &		Usual Residence of Decedent  10a. Slate 10b. County	100 (	City, Town o	or Location	_				10d. Inside City Limits
	Manyla	ō	MD Dorche		oity, rowire		le				1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	ester		Hurla	JCK		10a, Citize	on of Whal Cou	
	h with		6549 Palmers	Mill Road		2:	1643		-	ed St	•
	death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Decedent of H	lispanic Origin? (Spi	ecify Yes or No		I. Race - Ameri Black, White,	ican Indian,
36	or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2.☐ No		1 ☐ Yes 2 ☐ No	Specify:	riioari, oto./	1		hite
ie1d <b>21215-0036</b>	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or iteme 23a or 28a-f ehow ont, the Medical Examinar must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	169 0	ecedent's Usual Occup	ation			of Business/Ir	
1d	nin 72	Completed	(Specify only highest gra	ade completed)	(0	Give kind of work done ife. DO NOT use retired	during most of work.	ing			of Maryland
ie.	d with giene	mo.	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +	Ext	ension Ag	gent		Coop.	Extens	sion Svc.
sf	d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name			umame)	
in <b>yla</b>	should be nd Mental marked c	ပ္	Balvin Baccus Brinsf				Margaret				
Brinsf	d 2 sh h and 7 is n traum		19a. Informant's Name/Relationship (George N. Weeks,	**	F-1	Mailing Address (Street					
	is 1 end 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at		20a. Method of Disposition	20b	. Place of D	49 Palmer		Co., H		CK MD ation - City or T	
onna B Baltimore,	Page nent c ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	cemetery, Ld-Sho	ore Cremati				briďge	<u> </u>
Donna Baltimo	permit. Depertrimports eny inje		21. Signature of Funeral Service Licer Christine M	. Coale		22. Name and Addre 216 N. Mai:	ss of Facility Fra n Street,	amptom Federa	Funer 1sbur	al Home g, MD 2	e, P.A. 21632
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do no	t enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Gram ne	gati	re septic	almia				Hows
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of)	I duode		A n .			Dans
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of)		nat wi			-	13
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events								
oʻ	ificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as a conse	equence of)	:					
68760,	the br	edicai	•	d							
	= D d	/Mec	IF FEMALE:	22a If use outcome of prog							
Вох	eath certii ettending for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	′		23	d. Date of deliv Month	Pery Day Year
0	at the de by the r	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		- Carlot (apocally)					
G.	s that gned t	by P	Part II. Other significant conditions of	contributing to death but not re	esulling in t	he underlying cause giv	en in Part I.	23e. Did t	obacco use	coninbule to t	the cause of death?
ord	w requires been signi should be	ted	Metastatic	greast co	mce	~		10	Yes 2□	No 3 ☐ Pro	bably 4 []Unknown
Divislon of Vital Records, P.O	Physician: The law requires that the death cert this certificate has been signed by the ettendini ral director, page 2 should be deteched for use	Completed			·					24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
ital	ortifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deatl			, , , , , ,	
<u>&gt;</u>	Physician: this certific ral director,	ဥ	1 ☐ Yes 2 🖰 🔊 🗸 🗸	Hospital: 1 atient 2			4   Nursing Ho				fy)
טעכ	of the land	ion:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ury Wor		28d. Describe	how injury o	occurred	
islo	or Attending after death. Director: After in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not b	e Con Olean of Indian A	home farm		Yes 2 No	28f. Location (	Street and I	Number or Bur	ral Route Number,
Div	s after bid Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)	, otroot, radiory, office		City or To			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	29a Certifier 1 Certifying Ph (Check only 2 Medical Examons)	nywician: To the best of my ke niner: On the basis of examinand manner stated.	nowledge of nation and/o	seath conumed at the ti- or investigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	dauce(c) aid date and p	ilace, and due t	tated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	11 00		29c. Licens	/	~		signed (Month,	
		0	> Ludyano		9	90.	5 //4	-1	OCTOR	3EN 3	2006
			30. Name and address of reson who	lyanathan &	em 23a) (Ty	5 washin	igtin S	t. Eas	ton.	MD 2	21601
	Sta Registr		31. Date filed (Month, Day, Year)  OCT - 4 20	32. Registrar's Sign	nature	Joseph					

			1 - For Stete Registrar	State of Maryla		artment of H tificate of L			gienez Reg. No.	006	32506
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici: /Medic		Faye	Lynette	Cephas			Septem		22 2000	0515 M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of De			ounty of Death	1
			Memorial Ho	spital		Easto	20		To	Ibot	
	Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 F		h Your		place (State or Foreign
	Director		217-88-1412	I □ M 2月 F 46	Yrs.	Months Days	Hours M	In. (Month, Da Aug. 1, 1	960	Fla	intry)
-	9		Usual Residence of Decedent								
-	thow in high	_	10a. State 10b. County	10c. C	City, Town or Lo	cation					10d. Inside City Limits
	8 Ma	cto	Maryland Caroli	ne Fed	deralsb	ırg					1,12 Yes 2 □ No
4	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	untry?
	oealn with the Maryland ms 23a or 28a-1 show Imust be notified at	<u></u>	3003 Hargra	ves Ct.		21632			1	USA	
-		Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin?	(Specify Yes or No- lerto Rican, etc.)	- 14	Black, White	
2	or it	Ŧ	1 Never Married 2 Married	1 ☐ Yes 2 A No If Yes, Give		Yes 20 No	Specify:		S	pecify:	,
ocon-c	irel',	d by	3 Widowed 4 Divorced	Year or Dates:		-1				E	Black
5	"nati	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	lent's Usual Occupa kind of work done of	luring most of t	working	16b. Kind	d of Business/l	ndustry
7	hen hen	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired,	)		n	. 1 7	1 - 4 - 1
7	lygie hert hert	ပိ	12 17. Father's Name (First, Middle, Last		Vac	cinator	40 44-45-4-4	Name (Fire Address			latchery
מומ	atail H	Be						Name (First, Middle,			
Š	Merke	ဥ	Winifred	Aldridge			Nove		Cepha		
אם אם	le m		19a. Informant's Name/Relationship (					Rural Route Numbe			
5	end lealth m 27			Conaway /Siste			tersbur	g Rd. Hur			
5	of H		20a. Method of Disposition  1 DBurial 2 Cremation 3		Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date	20c. Loca	ation - City or 1	own, State
	permit. Fages 1 end 2 should be filed within 7.2 hours after death with the Marylan pergenteent of Health and Mental Hygiene. Important: if ferm 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		4 ☐ Donation 5 ☐ Other (Special			rg_Cemete				lock,Ma	
9	Deper Impor any In		21. Signature of Funeral Service Lices	1500	22			Bennie Smi			
4	40 E # 9		My xu xu	$\omega$		516 S. M	ain Sti	reet, Hurl	.ock,l	Marylan	d 21643
			23a. Part1. Exter the disease, or com shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not ent	er the mode of dying	g, such as card	diac or respiratory ar	rest,		Approximate Interval Between
Р	hysician		Immediate Cause (Final disease or condition	1 10000	00	ncer					Onset and Death
	/Medical		resulting in death)	Due to (or as a cons		VICOV					J. 1011-20
	xaminer		Sequentially list conditions,	b							
7	2 #	Examiner	Tany, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	iquence of):						
	and trans	am	that initiated events resulting in death) Last	c							
,00,	physicien and sthe burial-transit	<u> </u>	southing in doutin) Last	Due to (or as a conse	equence of):						
	hysic the b	dlcal		d							40.00
	ing p	Mec	IF FEMALE:								
5	ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregative birth 2 ☐ Fe	tal déath 3 □	Ectopic pregnancy			23	d. Date of delification of the Month	very Day Year
5	the a	Sic	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)				141011111	<b>54</b> )
	d by etach	Phy									
<u> </u>	e ign	۵	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	1/			the cause of death?
col da,	pino pino	ted	Multipld	an tailuv	~			- 1/2	/es 2 □	No 3 Pro	bably 4 Unknown
3	es be	ple	HIVE					24a. Was		24b. Were aut	topsy findings available ompletion of cause of
1 4	ate h	Completed						perfo	rmed?	death?	2 No
	tor	0	25. Was case referred to medical				26. Place of I	Death (Check only o			
•	direce	To B	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursin	g Home 5 Resid	dence 6	Other (Spec	ufy)
VISIOI O	ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe t	now injury	occurred	
2	ath. e fu	atlo	1 Natural 5 Pending 2 Accident investigation	n	,,		Yes 2 □ No				
2	ar de	불	3 ☐ Suicide 6 ☐ Could not b		home, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,
5 3	al De	Certification;		Daniality, oto. (Spot	,,,			ony or vo.	in, oldio,		
Civision of Vigal necology, r.C. DOA 001	The reprise to the design of the function of the foundation of the function of		29a. Certifier (Check only 2 Medical Example 1	nysicien: To the best of my ki miner: On the basis of examin	nowledge, death	occurred at the tim	e, date and planting	ace, and due to the	cause(s) a	nd manner as	stated.
1	in 24 the F	Medical	one)	and manner stated.	ianon and/or inv	realigation, in my of	Janon, Geath O	COUNTY AL LING IMIO,	oare and b	nace, and due	to the Cadab(s)
-	To the most	≥	29b. Signature and title of certifier	1. 0. (0	- 1	29c. License	number		29d. Date	signed (Month	, Day, Year)
			1	Nel X/1	10.0	DH	723	2	91	23 12	006
7			30. Name and address of pe n o	completed cause of death (Ite	om 23a) (Type,	Print)					
_	-		Mary S. Deshie	elds M.D., 401	Purdy	Street,	Easton,	Maryland	21601	<u> </u>	
	Sta		31. Date filed (Month, Day, Year)	Registrar's Sign		10.					
	Registr	ar	SEP 2 7 200	6							

State of Maryland / Department of Health and Mental Hygien [ ] [ 32507 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 24, 2006 0535 M Physician MARIE (URTIN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooke GroveRehabilitation and Nursing Center Sandy Spring

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2√□ F Yrs 198-14-4828 1925 Pennsylvania Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County ir than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 3330 N. Leisure World Blvd., #315 20906 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic School School Teacher other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fi of Health and Mental H Item 27 le marked otl 86 Owen Brennan Lucy May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18030 Cottage Garden Drive, #103, Germantown, MD 2087 James Gregory Curtin, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: if ite
eny injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUDDEN CARDIAC ARRHYTHMIA MINUTES **Physician** /Medical Due to (or as a consequence of): Examiner MONTHS HYPERTENSIVE HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physicien: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medicai use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year ŏ 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Physi 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ MBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 1☐ Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Alter 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier September 24, 2006 042046 UMT ATTENDING PHYSICIAN GRACE Brooke Hoffman, M.D. 18100 Stade School Road Sardy Spring, Maryland 20860
31. Date filed (Month, Day, Year) 32. Registrar's Signature 29 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Month Day September 19,2006 **Physician** Helen Wagner Carr 0030 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Min. (Month, Day, Year)

July 24,1920 Anne Arundel Medical Center Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX Yrs. 219-30-0584 86 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23e or 28a-1 show any njury or other treumatic avent, its Medical Expenses on 28a-1 show any njury or other treumatic avent, its Medical Expenses. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Queen Anne Grasonville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4931 Main Street 21638 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2**XX**No fYes, Give fear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XXX Specify: Specify: White þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Wagner Esther Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl W. Braun/Daughter 4931 Main Street Grasonville, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Waugh Chapel Cemetery 9/22/06 Gambrills, MD 4 ☐Dogration 5 ☐ Other (Specify) 21. Signature of Funeral Servi d Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Road Gambrills, MD 21054 Enter the disease or heart failure. Part1 shock or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death Cause (Final Physician Aguste on chronic renal fails re " to Multiple Infections + heart failure unh /Medical Due to (or as a consequence of): Examiner Metabolic encephalisthy secondary to Wemia in h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed C-diff Colitis wh that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical MRSA Cellulitis WALL IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Tyes 2 No : After this certifice e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes No No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 106 D 64089 MD on who completed cause of death (Item 23a) (Type, Print) Mark Sanchez M.1) 2001 Medical Purkway, Annapolis MO 2140, Registrar's Signature State Registrar

			For State Registrar	State of Maryla	and / D	epartment of F Certificate of I	lealth and N <i>Death</i>		2006	32509
	Physici	an	1. Decedent's Name (First, Middle, La Arthur		Davi	G Tra		2. Date of Death October	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	Lyons e street and number)	Davi		r Location of Death	october	4c. County of Dea	10:35 a M
	LITE		5720 Jefferson E  5. Social Security Number 6. S		re last hint	Frede:	rick   If Under 24 Hrs.	8. Date of Birth	Freder	
	Funeral Director			<b>X</b>		rs. Months Days	Hours Min.	Sept 24,	1934 Ke	thplace (State or Foreign ountry) ntucky
	land ow		Usual Residence of Decedent  10a. State 10b. County		City, Town	or Location				10d. Inside City Limits
	e Mary	ctor	Maryland Frederi	ck	Frede	erick				1 ☐ Yes 2 🛣 No
	ath with th 23a or 26 ust be no	Funeral Director	5720 Jefferson				21703		U.S.A.	ountry?
5-0036	ilied within 72 hours after death with the Maryland Hygiene. Ither than "natural", or iteme 23a or 28a-f show ith, the Medical Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 Amarried 3 □ Widowed 4 □ Divorced	I IANTOS ZI INO	1957 <b>-</b> 1959	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
21212-0	within 72 h lene. 'than "natu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)		Decedent's Usual Occup Give kind of work done of life. DO NOT use retired tt/Creative	d)		b. Kind of Business  Magazine	·
	m - 0 5	Be C	17. Father's Name (First, Middle, Last, Arthur Lyons		Can			e (First, Middle, Ma	-	
Maryland	should be and Mental I marked or	ဥ	Arthur Lyons  19a. Informant's Name/Relationship (		Sr 19b	Mailing Address (Street	Martha	al Route Number (	Brown City or Town State	Zin Code)
	ges 1 and 2 shoul it of Health and Me if Item 27 is mark or other traumati		Mrs. Lucille S. D	avis, Wife	57	20 Jefferso	on Blvd,	Frederick	, Marylar	nd 21703
Baltimore,	ment of Hi ment of Hi lent: If iten jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ♣ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from State Sn	cemetery	Disposition (Name of a crematory or other place) ourg Cremato	ory Oct 1	0,2006 S		Town, State g, Maryland
Ball	permit. Page Department Importent; If eny injury or once.		21. Signatury of Funeral Service Lice	///	0706	Keeney & 106 East C	Basford I	Funeral H	ome	701
I			23a. Part T. Enter the disease, or comshock, or heart failure. List only	plications that caused the do	eath. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ADENOCAP		MA OF 7	THE LUNG	<del>3</del> -		4 MONTHS
Ī	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of	n·				
2.	acuted ind transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events	c						
8/60,	icate be executed physicien and s the burial-transit	alEx	resulting in death) Last	Due to (or as a cons	sequence of	f):				
9		Medical	IF FEMALE:							
O. Box	at the death certifi by the attending lached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of predictions of the second s	etal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of de Month	olivery Day Year
ds, P	gned be de	by	Part II. Other significant conditions of	contributing to death but not	resulting in	the underlying cause giv	en in Part I.			o the cause of death?
tecords,	The law requir	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Vital H	iclan: The certificate his rector, page	e Cor	25. Was case referred to medical		_		26 Place of Door	performe 1 ☐ Yes 2 p		s 2□ No
	nysiclan: nis certific director,	ToB	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	? ☐ ER/Out	oatient 3 DOA Oth			ce 6 □Other (Spe	ecify)
on of	Attending Physiclan: or death. ector: After this certific. by the funeral director.		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Ti	me of 28c. Injury	yat k? Yes 2 □ No	28d. Describe how		
Division	5 9 5 6	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Blace of laive. A			TOS ELINO	28f. Location (Stre City or Town,		lural Route Number,
	To the Hospital cantification within 24 hours af To the Funerel D completely filled in		29a. Certifier (Check only 2 Medical Exar	ysician: To the best of my lininer: On the basis of exam	knowledge, ination and	death occurred at the tin	ne, date and place, pinion, death occur	and due to the cau	se(s) and manner a	s stated.
	rothe within 2 rothe to the to	Medical	one)  29b. Signature and title of certifier,	and manner stated.		29c. Licens	e number	290	l. Date signed (Mon	th, Day, Year)
)	/		> Swell of	and me	0	P	31761		10/9/2	ar
	20		30. Name and address of person who $BRANMLO$	completed cause of death (I	tem 23a) (1	ype, Print) W. SEVENT	# 87,	FREDERI	ek Mf	21701
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 2	completed cause of death (I	gnature	Ages the				

DHMH 17 Rev 1/2001

06-07517 Nic

Please Type or Print in Black Indelible Ink

cole Marie Duda	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Ren No. 2005 3251								
	Registrar	dlo Lost)	Cen	ilicate of L	Jealii 		Re 2. Date of Deat	9. 140	3. Time of Death
Physician/ edical Examine		rie Duda					Month October 5,	Day Year	1137 hrs
)	4a. Facility Name (if not institute 415 Yawl Drive	on, give street and number	er)		City, Town, or Lo	ocation of Dear	th	4c. County of Worceste	
Funeral	5. Social Security Number	6. Sex 7	Age (In yrs, las	st birthday)	If Under 1 Year	If Under 24H		h(MM/DD/YYYY)	9. Birthplace (State or Foreign Pennsy1-
Director	185-64-1588	1 M 2 X F	22	Yrs.	Months Days	Hours Mi	January	y 1984	Country) vania
aus	Usual Residence of Decedent  10a. State 10b. County	,	10c. City, 7	Town or Location	1				10d Inside City Limits
A C	Maryland Free	derick		Monrovi	2				1 Yes 2 X No
the Maryland a or 28a-f sh tiffed at one Director	10e. Street and Number	CLICK			10f. Zip Code		10	g. Citizen of Wha	t Country?
vith the Maryland 123a or 28a-f show a contified at once. al Director		e Circle			21770				States
r death with the Maryland or items 23a or 28a-f she must be notified at once Funeral Director	11. Marital Status  1 X Never Married 2	12. Was Decede Married Armed Force	s?		Decedent of Hispa , specify Cuban, N		Specify Yes or No- to Rican, etc.)	14. Race - White,	American Indian, Black, etc.
ter dez ", or i er mu		1 Yes	2 X No	1 Y	es 2X No	specify:		Specify:	White
hours after natural", c		ecify only highest grade of	ompleted)		Usual Occupation t of working life. D			16b. Kind of Bus	iness/Industry
1 2 E E	Elementary/Secondary (0-12	) College (1-4	or 5+)			O NOT use re	alled)		
5-003 led withi Lygiene other th	12 17. Father's Name (First, Middle	e, Last)		Wait	ress 18	Mother's Nam	ne (First, Middle, N		nd Beverage
21215-0036 old be filed within 7 Mental Hygiene marked other than c event, the Medica To Be Compile						Jacque1	ine M. B	oskovito	eh
more, MD 21215-0036 Pages 1 and 2 should be filed within tent of Health and Montal Hygiethea uni. If item 27 is marked other the prother traumatic event, the Medic To Be Compil	19a. Informant's Name/Relation						Rural Route Num		
timore, MD 2's and 2 should timent of Health and M riant: If item 27 is m or other traumatice	Joseph Duda /	Father	20b. P		illstone		e Monre		ryland 21770 City or Town, State
Baltimore, permit. Pages I are Department of Hee Important: If iten injury or other tr	1 X Burial 2 Crematic		State	rematory or othe		Oct	tober		1 W 1 1
Baltimo permit. Page Department of Important: injury or oth	4 Donation 5 Other S	Specify: e Licensee	Mt.	22. Na	Cemeter me and Address o				ck, Maryland Iomes, P.A.
in in the Ba	Jams A	, Ja	$\sim$			ille B1	vd. Mt.	Airy, M	Maryland 217 <u>71</u>
Physician / /Medical	23a. Pagt I. Enter the disease of failure. List only one caus	e on each line						est, shock, or hear	Between Onset and
xaminer	Immediate Cause (Final diseas or condition resulting in death)	e a Alcohol,  Due to (or as a co			hadone int	oxicatio	n		Death
	Sequentially list conditions,	b							
iner	if any, leading to immediate cause. Enter Underlying Cause		nsequence of)	):					
led Insit Examiner	(Disease or injury that initiated events resulting in death) Last	D 1- /	nsequence of)	):	-	-			
and and	X UNPENDED	dAMENDED :	""		15.000	10/10/	'oc		
	IF FEMALE:	23c. If yes, out			perME,g860	, 10/18/	06 TT	23d Date of d	delivery
lox 6876 (eath certificate attending phy for use as the backing party)	23b. Was decedent pregnant in past 12 months?	the 1 Live birth		2 Feta	I death 3	Ectopic preg	nancy	Month	Day Year
the death certificate the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 🗸 U	1 ' -		5 Othe	er (Specify)				
Division of Vital Records, P.O. Box 68766 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcard Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/Medical Certification:		itions contributing to de	eath but not re	sulting in the un	derlying cause giv	en in Part I.			oute to the cause of death?
IS, P quires t en sign ald be d							1 Yes		Probably 4 Unknown  Vere autopsy findings available
of Vital Records,  ng Physician: The law require.  The this certificate has been signered director, page 2 should b.  To Be Completed				_			autop	sy pr	for to completion of cause of eath?
tal Rection: The certificate ector, page		2			26 Place o	of Death (Chec	1 Yes	2 No 1	Yes 2 No
Vital hysician: this certil I director	examiner?	1 Ioonital:	atient 2	ER/Outpatient		thor:		Residence 6	Other: Scene
of Viing Physical Chineral discussed in:	27. Manner of Death	28a. Date of (Month, Da	njury y,Year)	28b. Time of Inju			28d. Describe l	now injury occurre	d
ivision or Attend after death. Director: I in by the f	1 Natural 5 Pe	estigation Fnd 10/		Fnd 11:!5	CHILI	s 2 X No	unk		
Division of spiral or Attending I nours after death. If Itled in by the funet. Certification:	3 Suicide 6 X Co	uld not be ermined (Specify)		me, tarm, street, n residen	factory, office bui	ilding, etc.	or Town S	street and Number state) 415 Ya Lty, MD	r or Rural Route Number, City wl Drive
Division  To the Bopiral or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29a Lentier	Physician: To the best of				e and place, a			
Fo the Bawithin 24 To the Facompletel	one) 2 Medical Ex	aminer: On the basis of e		nd/or investigatio	n, in my opinion, o	death occurred	d at the time, date	and place, and du	ue to the cause(s)
حَ ا ` ` ` ` ق					29c License	number		29d. Date signe	d (Month, Day, Year)
					0014	I E		October	
	Jasha	Geefm		22->	O.C.M	I.E.		October 6,	
		Heef in who completed cause of	of death (Item		O.C.M		/ID 21201	October 6,	

Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

toger bupies		1- For State  Certificate of Death Registrar		J. No. 200	6 32512
Physicia	n/	1. Decedent's Name (First, Middle,Last)	<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death 1312 hrs
Medical Examir		Roger Firmin Duprey, Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	October 1,	2006 4c. County of Death	
		Penninsula Regional Medical Center Salisbury		Wicomico	' <u> </u>
Funeral			8. Date of Birth	n(MM/DD/YYYY) 9. Bir	thplace (State or
Director		217-80-6608 1XM 2F 42 Yrs. Months Days Hours Min.	07/28/	1964 Foreig	untry) Maryland
w any	- 1	10a State 10b. County 10c. City, Town or Location			10d Inside City Limits 1 Yes 2X No
Maryland 28a-f show 1 at once.	ğ	Maryland Wicomico Newark	140	- Cities - FIATh-1 Co	
th the Maryland 23a or 28a-f she notified at once	<u>e</u>	10e. Street and Number 10f. Zip Code 21841		g. Citizen of What Cou ${f USA}$	ntr <b>y</b> ?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? ( Specific Yes, specify Cuban, Mexican, Puerto R		14. Race - Amer White, etc.	ican Indian, Black,
fter de F. or		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify		Specify Whi	te
ours a	함	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		16b. Kind of Business/	Industry
6 172 hu an "n cal El	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	(4)		
003 within giene. ner th	E .	12 Painter  17. Father's Name (First, Middle, Last) 18. Mother's Name (I	First Middle M		al/commercia
1215-0036 Id be filed within 77 fental Hygiene. narked other than event, the Medical	Be C	Roger F. Duprey, Sr.  Joan Coc			
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygienc. item 27 is marked other than r traumatic event, the Medica	E P	19a, Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Ru			e, Zip Code)
and 2 shou sealth and N tem 27 is r		Joan C. Harrell/ mother 271 S. Washington Str	eet, Sr	ow Hill, M	D 21863
e, ML  I and 2 s  Health as  Fitem 27  r traums	1		Date	20c. Location - City or	Town, State
Limore Pages 1 ament of Blant of Blant of or other t	4	12 Duild 2 Grenation 3 Removal noni state:	6/2006	Ridgely,	Maryland
Baltimore, permit. Pages I at Department of Bee Important: If ite	1	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility Fleegle and Helfenb	ein Fur	eral Home.	PA
	4	PO Box 160 Greensbo 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or i	ro, MD	21639	Approximate Interval
Physician /Medical		failure. List only one cause on each line.	respiratory arre	st, shock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Complications of head injury  Due to (or as a consequence of):			Death
		Sequentially list conditions,  b			
	ner	if any, leading to immediate cause. Enter Underlying Cause			
	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
cuted nd transit		d		<u></u>	
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
760, icate be physic the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live bith 1 Fetal death 3 Fetal death 3 Fectoric pregnancy		23d. Date of deliver	<b>1</b>
Box 68 e death certifithe attending ed for use as	Physician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify)	су	Month	Day Year
Box death he atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
that the death certifulate by the attending		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
ords, P.C. w requires that as been signed be seta	d by		1 Yes	2 V No 3 Pro	bably 4 Unknown
ords	Completed		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
teco The law ate has	E		perform		es 2 No
Vital Rechysician: The this certificate	BeC	25. Was case referred to medical 26 Place of Death (Check or	nly one)		
Vita hysici this c	일	Tes 2 No		Residence 6 Othe	r:
After Fune	Ë		28d. Describe h Subject fell	ow injury occurred	
Sio Atten r deatl ector: by the	Sati	2 🗸 Accident Investigation	28f Location (S	treet and Number or Ri	ural Route Number, City
Divi	Certification:	Suicide 6 Could not be determined (Specify) Single Family	or Town, St		
Hospit 4 hous Funer	ပ္	29a. Certifier . Denotation To the heat of multipopulation double and allow and place			
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	the time, date a	and place, and due to the	ne cause(s)
7.37.8	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (Mo	onth, Day, Year)
		Joshe Seef UD O.C.M.E.		October 2, 2006	
	İ	30. Name and address of person who completed cause of death (Item 23a)	0.10		
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	-	00) 4 (100)			

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9:am CORNELIUS L. Sept 2006 GASSAWAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year)
June 27,1940 Maryland Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. Tast birthday) **Funeral** Months Hours 1[**¥**M 2□ F 66 Director 579-52-6944 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthen "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 2 □ No Director Hyattsville Prince George Md 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20784 4816 Rockford Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married imore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Park & Planning 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then \*r Elementary/Secondary (0-12) College (1-4or 5+) Commission 12th Grade Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Blanche Taylor James Gassaway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tra-4816 Rockford Dr. Hyattsville, Md 20784 (Wife) Florence E. Gassaway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ash Memorial Cem. 9/30/06 Sandy Spring, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.A. 20850 Md Approximate Interval Between Doset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo Cauly tarctur /Medical Due to (or as a consequence of): Examiner Perlimmone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of) Due to (or as a consequent Examiner The law requires that the death certificate be executed Ischemie been signed by the attending physicien and should be detached for use as the buriat-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Y ... MAYOR: Des in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. F 9 Unknown 9 Unknown 23e. Did tobacco use cogtribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 □Unknown disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 1 Yes pertension or Attending Physician: 25. Was case refer d to 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 1 Inpatient CFVOutpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confier DO0470 10 Ku 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Surfe 270 Camil SUNG B.KIM 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 29 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Theresa M Harve	•	Sta	te of Maryla				Menta	l Hygiene	Э			
		Registrar  1. Decedent's Name (First, Middle	Last)	Cer	tificate of	Death		2. Date		g. No. 20	100	3,251
Physicia Medical Examir		THERESA MA		Ϋ́						Day Year 2006		1340 hrs
1 mg		4a Facility Name (if not institution 1046 Conowingo Road	give street and nur	nber)	4	b. City, Town, or L Rising Sun	ocation of	Death		4c. County of Cecil	Death	
5			S. Sex	7. Age (In yrs. la	est highday)	If Under 1 Year	If Under :	24Hrs Is Dat	of Rid	h(MM/DD/YYYY)	9 Rinth	place (State or
Funeral Director		201 60 4066	1 M 2 XF	43		Months Days	Hours	Min			Foreign	
	ŀ	Usual Residence of Decedent		13	110.	1 1		1003	-1 -	3, 1303		
w any		10a. State 10b. County PA Montgo	moru		ng of P					-		10d. Inside City Limits
yland P-f sho	핡		_	[	_	10f. Zip Code			110	g Citizen of Wha		1 Yes 2 XNo
or 283	Director	10e. Street and Number King 351 Hilltop Dri	swood Apa ve. Ant	rtments 334		1940	6			United S		
ceath with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	12. Was Dece	edent Ever in U.		Decedent of Hisp	anic Origin		or No-	14. Race -	America	an Indian, Black,
r death	Funeral	1 Never Married 2 Mar	1 Yes	2 🗓 No		es, specify Cuban,		rueno Rican, e	(C. )	White,		<b>.</b>
irs afte	ā	3 Widowed 4 X Divo	rced If Yes, Give Year or Dates: fy only highest grad			Yes 2 X No		nd of work done	9	Specify: 16b. Kind of Busi	Whi ness/Inc	
72 hou	leted	Elementary/Secondary (0-12)	College (1-		during mo	ost of working life. I	DO NOT us	se retired)		TT	~	
5-0036 iled within 7/ Hygiene. d other than the Medical	Comple	12			Secu	rity Gua:		Name (First M	alata Na	Unisys	Corp	poration
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, L Joseph F.				1"		is E. V		laiden Surname)		
2121: ould be fil d Mental B s marked lic event,		19a. Informant's Name/Relationshi	p (Type, Print )		19b. Mailing	Address (Street	and Number	er or Rural Rou	ite Num	ber, City or Town,	State, 2	Zıp Code)
MD nd 2 sho m 27 is aumat		Rose Mary Harve	y/Sister	Look		lexander			exel	Hill, P		
Ore,		20a. Method of Disposition  1 Burial 2 XCremation	3 Removal fro	m State	rematory or oth A. Ferr	er place)		Date 10/7/06				
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spe 21 gn ture of Funeral Service		7		ame and Address		10/ // 00	,	West Ch	este	EL, PA
Ba Perm Depa Impe		Jelly Vo	Tout	ill 8		rkins Fur		Home,	Inc	., Delta	, PA	
Physician		232 Part I. Enter the disease, or of failure. List only one cause of	omplications that can each line.	used the death.	Do not enter th	e mode of dying, s	such as care	diac or respirat	ory arre	est, shock, or hear	t	Approximate Interval Between Onset and
/Medical xaminer	4	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inju	ıri <b>e</b> s							-1	Death
		Sequentially list conditions,	Due to (or as a b	consequence of								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of	f):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):							
0, c. be executed sician and ourial - transi	edical E	UNPENDED	dAMENDED				,				$\dashv$	
60, ate be a hysicia	Medi	IF FEMALE:	172-0-1-0	outcome of pregi	nancy					23d. Date of d	elivery	
6876( certificate nding phy-	au/	23b. Was decedent pregnant in the past 12 months?	1 Live bi		2 Fel	al death 3	Ectopic p	oregnancy		Month	Da	ay Year
Box e death c	Physici	1 Yes 2 No 9 V Unkr			ath 5 Oth	ner (Specify)						
on the deby etach	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause gr	ven in Part	I. 23e				ne cause of death?
ls, P		<u> </u>						249	. Was a			ubly 4 Unknown
tal Records rian: The law requi certificate has been ector, page 2 should	Completed							_   _	autops	sy pri		mpletion of cause of
Rei r: The ifficate		25. Was case referred to medical	<del> </del>			26 Place	of Death (C	heck only one	Yes 2	2 No 1	<b>✓</b> Yes	2 No
Vital Rec ysician: The his certificate I director, page	o Be	examiner?	Hospital: 1 1	npatient 2	ER/Outpatient		)thor ==	Nursing Home	5 🔲 1	Residence 6	Other:	Scene
1 of Vi	$\vdash$	27. Manner of Death	28a. Date (Month) Oct 3, 20	of Injury Day,Year)	28b. Time of Ir		at Work?	Onerat		now injury occurred motorcycle in		l in collision
ivision or Attend after death Director:	atio	1 Natural 5 Pendii 2 ✓ Accident Invest	igation		1338 hrs		es 2 🗸 N	10				
Division of Vital Records, pital or Attending Physician: The law requirement after death. Therefore After this certificate has been sittled in by the funeral director, page 2 should be.	ertification:	determ	not be	Local Stree		t, factory, office bu	iliding, etc.	or T	own, St			al Route Number, City
To the Hospital within 24 hours: To the Funeral	O	20a Certifier	siclan: To the bes			red at the time, dat	e and place					
To the Hos within 24 h To the Fur completely	edical		iner:On the basis of and manner st		nd/or investigat			irred at the time	e, date a	and place, and du	e to the	cause(s)
	Σ	29b. Signature and title of certifier	.100	00		29c License				29d. Date signed		h, Day, Year)
		20 Name and address of the	HUL	XUV	220)	O.C.N	1			October 4, 2	000	
6		<ol> <li>Name and address of person value.</li> <li>Carol Alian, MD Ass</li> </ol>	vno completed caus istant Medical I	_ '		Street, Baltimo	re, MD 2	21201				
	ate	31. Date filed (Month, Day, Year)	anar P	gistrar's Signatu	ire,	A STATE OF THE STA		<u> </u>				
Regist	rar	OCT 1 2	2006	1988 1 Buch S	B. Palan							

DEIMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year :02 M **Physician** ctober 2006 Owl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ponar If Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace/(State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 200F Yrs. 89 12,1916 Ohio Dec. Director 171-14-7205 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 end 2 should be filed within 72 hours elter deeth with the Maryla Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any Injury or other treumetic event, the Medical Examiner must be notified at ODG. 1 ☐ Yes 2 No Director MD St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 20659 27107 Erin Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 22 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: Completed by 3€3Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Klingensmith Hattie Kooser 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27107 Erin Drive Mechanicsville, MD 20659 Robert S. Robbins / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 6, 1 ☐ Burial 22 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 2006 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols Funl. Hme., P.A. 21. Signature of Funeral Service Licensee M00641 30195 Three Notch Rd. Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** minuk disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury onsequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): .O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day be deteched for 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑ Inknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pege 2 1 Yes 2 0 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ № this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident efter death Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Thomicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and add iss of person who completed cause of geath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

Registrar

OCT 0 6 2006

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	l / Depa	artment of rtificate of	Health a	nd Ment	al Hygien	2006	32517
	Physici	an	1. Decedent's Name (First, Middle, Last	)			-			ay Year	3. Time of Death 0 8 1 5 M
	/Medio		Dorothy D. High 4a. Facility Name (If not institution, give Montgomery General			4b. City, Town, Olney				c. County of Dea	
	Funeral Director		5. Social Security Number 6. Se 1577-09-4217	7. Age (In yrs. Ia:	Yrs.	If Under 1 Yea Months Days		Min. (M	ate of Birth fonth, Day, Year Ch 1, 1	) 0	rthplace (State or Foreign ountry)
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f ehow the Madical Exeminer must be notified a	Director	Maryland Montgon	nery S	ilver	Spring 10f. Zip Code			100.0	itizen of What C	1 ☐ Yes 🛣 ☐ No
	3a or	al Dir	15111 Vantage Hi	11 Road		20906			log. C	USA	ountry :
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of f Yes, specify Cu		in? (Specify Y	es or No-	14. Race - Am Black, Whi	
980	ors after	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1  Yes 2 Kixio If Yes, Give Year or Dates:		1 ☐ Yes 2 No			, 5.0.,	SpecifWhit	
2-0	72 hou	eted	15. Decedent's Edu (Specify only highest grad	ication de completed)	16a. Dece	dent's Usual Occu	pation	of working	16b.	Kind of Business	s/Industry
21215-0036	within ene. then	Jdwc	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir rvisor	ed)		Tele	phone Co	ommunication
land 2	id be filed ental Hygi ked other ic svant, I	To Be Co	17. Father's Name (First, Middle, Last) Frank Duvall				18. Mother	's Name (First	t, Middle, Maide		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show says injury or other traumatic avant, the Madical Examination at 2000.	-	19a. Informant's Name/Relationship (7) Steven Brand/ Ne		19b. Mailir 7807	ng Address <i>(Stree</i> Breaksto	ot and Number one Cou	or Rural Rout rt, El	te Number, City licott	or Town, State, City, MI	Zip Code) D 21043
Baltimore,	Pages 1 a sent of Hec nt: If itsm ry or oths		20a. Method of Disposition  1 XBurial 2 Cremation 3 I  4 Donation 5 Other (Specify,	Removal from State	netery, crer	sition (Name of natory or other pl 1 Cemete	, , 0	Date October 2006	2,	ocation - City o	2000
Balti	permit. Departm Imports sny inju		21. Signature of Funeral Service Licens	0,000,000	$\mathbf{F}^{22}_{\mathbf{r}}$	Name and Add	ess of Facility	ns Fun	eral Ho	me Inc.	g, MD 20901
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	Do not ent	er the mode of dy	ing, such as c	ardiac or resp	iratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneuwon'd							Onset and Death
	Examiner	Jer	if any, leading to immediate	b	ence of):			-			
	te be executed ysicien and le burial-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
		Icai		d							
P.O. Box (	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pregnance 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	olivery Day Year
ds, P	ires that signed to the det		Part II. Other significant conditions co	ntributing to death but not result	ting in the ur	nderlying cause g	iven in Part I.	2:	3e. Did tobacco		o the cause of death?
COL	w requir been si should	letec		Teckar					4a. Was an		utopsy findings available
Vital Records,	hysician: The law his certificate has b I director, pege 2 s	Completed	bar KIDSOU ISM				•		autopsy performed?	prior to death?	completion of cause of
Vita	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		10	thec	of Death (Che			
o	ding Phys h. After this funeral di	5	27. Manner of Death	28a. Date of Injury 2	R/Outpatien 8b. Time of	t 3 DOA	7 14013		Residence rescribe how inju	6 Other (Spe	ecify)
sion	Attending in death.	atio	1 PNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		onk? ∐Yes 2.∐N	О			
Division of	Hospital or Attand 44 hours efter deatl Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office			ocation (Street a ity or Town, Stat		Bural Route Number,
	To the Hospital or Attenwithin 24 hours effer deati To the Funeral Director: completely filled in by the	Medical (	29a. Certifier Certifying Phyone (Check only one) 2 Medical Example 1	sician: To the best of my knowliner: On the basis of examinatio and manner stated.	ledge, death on and/or inv	n occurred at the restigation, in my	time, date and opinion, death	place, and du n occurred at t	ie to the cause( he time, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
1	To the To the complet	W	296. Signature and title of certifier			-	Se number	(	29d. Da	ate signed (Mon	th, Day, Year)
,		4	30. Name and address of person who co			Print) no ce That.	Dive	, Olner	, lay	and 208	32
	Sta		31. Date filed (Month, Day, Year)	B2 Registrar's Signatur	re		4	, = (	),		
CLU	Registr MH 17 Rev 1/20		SEP 29 200	16 Hours &	1600						

OFIGINAL

			•	State of Marylar	nd / Depa		lealth and M	lental Hy			325	18
激	- Physicia	an	Decedent's Name (First, Middle, Last)     Thomas Newton	Hardes	tv	-		2. Date of De		2006	3. Time of 9:36	Death p M
	/Medic Examin	al	4a. Facility Name (If not institution, give si Mandarin House			4b. City, Town, or	r Location of Death		4c. C	ounty of Death	1	P
<b>5.</b>	Funeral Director	A	Social Security Number	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir April 2	th 18 , 19 1	9. Birtl	place (State o	r Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State  10b. County  MD  Anne Aru		ty, Town or Lo	ocation					10d. Inside Cit	
	with the ta or 28s	Direc	10e. Street and Number 12 Swallow Lane			10f. Zip Code 20776			_	en of What Co		
0000	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Amental Hygiene. Amental Frammer must be notified at after event, the Medical Exammer must be notified at	by Funeral Director	11. Marital Status 1  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		A. Race - Ame Black, White Specify: Wh	e, etc.	
5	"natura "natura edical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing	16b. Kind	d of Business/	Industry	
7 7	d withii giene. or then	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Farme				Agric	culture		
aua	be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name Daisy Bu	•	, Maiden S	lumame)		
0	and and	To	Robert L. Hardesty  19a. Informant's Name/Relationship (Type Marjorie J. Morela	pe, Print)			and Number or Run eland Pla	al Route Numb			(ip Code)	
מה	Pages 1 and 2 ent of Health nt: if item 27 i ry or other tra		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			osition (Name of matory or other place ary Cem.	9/27/	Date 2006		ation - City or		
Daitimor	permit. Pages 1 Department of the important: if ite any injury or ot once.		21. Signature of Funeral Service License	ө	22	2. Name and Addre	ss of Facility Har ville Roa	desty I d Gales	Tunera svilla	al Home	P.A. 20765	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the deal e cause on each line.  Memo	7578°		ng, such as cardiac		MCC	N.	Approximat Interval Bet Onset and	ween
,	le be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse								
68/6U,	cate be ohysicia the buri	cal	<b>U</b> d									
C. Box 6	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3[	□Ectopic pregnancy □ Other (specify) _	y		23	3d. Date of del Month		Year
ras, r.	requires that the de peen signed by the a hould be detached f	Š	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	underlying cause giv	ven in Part I.			/	the cause of cobably 4 🗆	
Hecord	elaw hast	Completed						24a. Was auto perf 1 Yes		24b. Were at prior to death?	utopsy findings completion of c	available ause of
Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		at all post Ott	26. Place of Deat			V	HOSP	Œ
5	Phys this	7: To	1 Yes 2 No	28a. Date of Injury	28b. Time o	THE SELECTION	4   Nursing ric	ome 5 ☐ Res 28d. Describe			city) לעסול	32
Division	Hospital or Attending 24 hours after death. Funaral Director: After tely filled in by the fune	Certification:	1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	Injury	M 1 🗆	rk?  Yes 2 □No		(Street and	Number or Ri	ural Route Num	nber,
5	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	lowledge, deal	th occurred at the time	me, date and place,	and due to the	cause(s)	and manner as	s stated.	5)
	To the H within 24 To the F complete	Medical	29b. Signature and title of centrier	and manner stated.	W	29c. Alcens		4		signed (Mon		
			30. Name and address of person who co	JEAN BINO	23a) (Type	Prints 657	SASTER	0380	Am	MPS	215 W	M
36	Sta	ato	31. Date filed (Month_Day, Year)	Registrar's Sigr	najure /	1						

DHMH 17 Rev 1/2001

Registrar

06-07565 Karen Hopkins Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) Date of Death Physician/ **Medical Examiner** Karen Hopkins 1244 hrs October 7, 2006 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Director Davs Hours Min 220-90-8508 M 2 **X** F -43Country)Maryland Yrs May 25 1962 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 Yes 2 X No or items 23a or 28a-f shormust be notified at once. MD Anne Arundel Gambrills Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 2253 September Drive 21054 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? death 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes 2 X No after Widowed Yes, Give Yea 4 Divorced Yes 2 X No specify marked other than "natural", ic event, the Medical Examiner Specify White ş nours 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "r
injury or other tranmatic event, the Modi I E College (1-4 or 5+) Baltimore, MD 21215-0036 Disabled Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William Hopkins Shirley Jarboe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Mullins (Sister) Joyce Lane, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Lakemont Mem. Gardens 10-14-2006 Other Specify Davidsonville, MD 21. Signature of Funeral Service Cre 22 Name and Address of Facility
Hardesty Funeral Home, P.A 851 Annapolis Road, Gambrills, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of): Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Physician/Medical x AMENDED 7 X UNPENDED attending physician or use as the burial ,23a,27,perFH,ME,g860, 10/30/06 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown 9 ned by the a detached fo Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by ģ 1 Yes 2 No 3 Probably 4 Unknown Completed s been si should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has page 2 performed? death? Yes 2 No 1 🗸 Yes 2 No funeral director. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the f Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month trar's Signatu State 0

Registrar

			State of Maryland / Dep	artment of Health and N rtificate of Death			32520
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodic of Dodin	2. Date of Death	g. No.	3. Time of Death
	Physici		Mary Anna Hayman		Month Oct (	Day 2006	8:56 A M
V	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	LAGITIT	٠.	12234 Garland Road	Greensboro		Caroline	e
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Q Rint	hplace (State or Foreign
	Director		218-40-6353 1 M 2 T F 63 Yrs.	Months Days Hours Mill.	Jan 4 19	Mary	yland
	pu .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ncation			10d. Inside City Limits
	lanyla Pho	5					1 ☐ Yes 2 ▼ No
	the N	ect	Maryland Caroline Greensbo	10f. Zip Code	10	og. Citizen of What Co	unitry?
	with	늅	12234 Garland Road	21639			army.
	death with the Maryland me 23s or 28s-f show rmust be notified at	by Funeral Director				JSA 14. Race - Ame	nican Indian,
^	r Itan	Ξ	1 Never Married 2 X Married 1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
2000	el'.o	Ď	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	.te
<b>-</b>	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	ident's Usual Occupation	una 1	16b. Kind of Business/	Industry
V	ithin	d d	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	9		
7	led w lygier her th	Ö		memaker	e (First, Middle, M	own home	9
/land	be fi	Be	17. Father's Name (First, Middle, Last)			naiden Surname)	
Ž	d Me d Me mark matic	ဥ	Raymond Vogt  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Margare ing Address (Street and Number or Ru.		City or Town State	Zin Codel
Z	d 2 s th an traur	1	1111	4 Garland Road Gre		•	
ē,	Heal Heal tem 2		The state of the s	osition (Name of matory or other place)		20c. Location - City or	
2	ages ont of t: H il	11	Modular 2 Cremation 3 Chemoval non State	ı	5 2006 6	?	Marril and
апптог	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. In proprient: If Item 27 is marked other than "natural", or items 23a or 28a-f show any jointry or other traumatic avant, the Medical Examination at 2000.  DDGs.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility		Greensboro	
ă	Deperiment of the periment of		Here Oflech	leegle and Helfen O Box 160 Greensb	bein Fune	Tand Home 3	PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			.,	Approximate Interval Between
	Physician		Immediate Cause (Final	Mother	grape		Onset and Death
	/Medical		disease or condition resulting in death)  a. Jiohlas Coyda  Due to (or as a consequence of):	110000112			0007/1_5
	Examiner		Sequentially list conditions				
-	D 75	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and trans	Examiner	mat initiated events .				
Š	certificate be executed adding physicien and use as the burial-transity.	E E	resulting in death) Last Due to (or as a consequence of):				
00/00	physi the b	dical	d				
XO	w requires thet the death certific been signed by the attending p shuuld be detached for use as	hysician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	iven
	atten atten I for u	clan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
j.	the d y the iched	ysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown				
F	requires thet the death een signed by the atter hould be detached for u	•	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
200	quires n sign	q pe			1 ☐ Ye	s 20 No 3 □ Pr	obabiy 4 🗀 Unknown
5 2 8	s bee	Completed by			24a. Was ar		itopsy findings available
Ĕ	sicion: The law certificete has b irector, page 2 si	E			autopsy perform	ned? death?	completion of cause of
		Bec	25. Was case referred to medical	26. Place of Dea	th Check only one		
<u>-</u>	Physician: this certific ral director,	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing H	ome 50 eside	nce 6 ☐Other (Spe	cify)
5	ng Pi		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year) Injury	Work?	28d. Describe ho	w injury occurred	
Vision	tendi leath. tor: A the fu	catl	2 Accident investigation	M 1 Yes 2 No			
₹	or At	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town,	reet and Number or Ri , State)	ural Houte Number,
-	To the Hospital or Attanding Phys within 24 hours either death.  To the Funeral Director: Aller this completely filled in by the funeral directors.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and class	and due to the	uea/e) and manner -	estated
	24 h	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rvestigation, in my opinion, death occur	rred at the time, da	ite and place, and due	to the cause(s)
	To th within To th sompl	Me	29b. Signature and tyle of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
			I Jamas Sular M	D31376		10-2-00	7
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	*	10-2-06 UTDU	10
			James Siles 920 /	larket St	Del	utor	195
	Sta		31. Date filed (Month, Day, Year)  OCT - 4 2006  32 Registrar's Signature	nall 1			
	Registr	ar i	THE COURSE THE COURSE THE THE PROPERTY AND THE PROPERTY A	Contract of the second			

		•	For State Registrar	State of Man	-	partment of I ertificate of			2006	32521
	Physicia /Medic	aľ -	1. Decedent's Name (First, Middle, Last)  A R S  4a. Facility Name (If not institution, give s	MM A	HA	4b. City, Town,		2. Date of Death Month OCTOBER	Day Year O1 2000 4c. County of Death	
	Funeral Director		218-10-0423	PITAL a 7. Age (I	In yrs. last birthda	Months   Davs	STON r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Gay, Y	9. Birth Coy	place (State or Foreign
e Maryland	a or 28a-f show be notified at	ctor	Usual Residence of Decedent  10a, State  10b, County  CARDI	INE 1	oc. City, Town or RID61	<b>5</b> 2 <i>y</i>				10d. Inside City Limits 1
with the		Funeral Director	209 CAROL	INE A	VE	10f. Zip Code	1660		J. Citizen of What Cou	
AR# E0518938	/01/06	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 1	13. Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 No.	Hispanic Origin? (Spe ban, Mexican, Puerto I o Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
84 MR#	Adm: 10/01/06	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(G life	acedent's Usual Occu live kind of work done e. DO NOT use retir omemaker	e during most of workii		own home	ndustry
	22	Be	17. Father's Name (First, Middle, Last) Ralph Cole				18. Mother's Name	(First, Middle, Ma l Buckle	uden Sumame)	
<b>3Y E</b> <b>922 /</b> 44209 ED		<sup>2</sup>	19a. Informant's Name/Relationship (Type			,	et and Number or Rura	l Route Number, (		
HALL, MARY E DOB: 02/17/1922 Age: Acct: E00000442096 REG ER E.ED			Darlene E. Kirby/ 20a. Method of Disposition 1 X Burial 2 Cremation 3 R		20b. Place of Di	O Caroline Sposition (Name of crematory or other pl			ryland 2166 Oc. Location - City or T	
HALL DOB: 0. Acct: EC REG ER			4 □Donation 5 □ Other (Specify)  21. Signature of Fuperal Service License				ery Oct 5 ress of Facility nd Helfenbe			, Maryland
7048	¥ ===		23a. Part1. Enter the disease, or compli	fly		PO Box 160	) Greensbor	o, MD 21	.639	Approximate
Ph	ysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.			FARCTIC			Interval Between Onset and Death
E	Medical wad water and the parial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a control of the contr	consequence of):	POTO CA	RDIO VASC		Okar (	CHRONIC
). Box 6	the attending ph	Physician/Me	IF FEMALE:						<del></del>	
O g	~ 0	ys	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 Ectopic pregnan 5 Other (specify)			23d. Date of deli Month	very Day Year
ds, P.O.	gned by se detac	þ	in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \bar{\mathbb{N}} \) No	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death me of death	5 ☐ Other (specify)			Month acco use contribute to	Day Year
	ite has been signed by page 2 should be detac	Completed by Physi	in the past 12 months?  1 ☐ Yes 2 ■ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death me of death	5 ☐ Other (specify)			Month  acco use contribute to 2 No 3 Pro  24b. Were au prior to c death?	Day Year the cause of death?
on of Vital	n. After this certificate has been signed by funeral director, page 2 should be detac	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions condition	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death me of death not resulting in th	5 ☐ Other (specify)  The underlying cause gratient 3 ☐ DOA Cape of 28c. In the part of th	given in Part I.  26. Place of Death  2ther: 4 □ Nursing Ho	1 Yes  24a. Was an autopsy perform 1 Yes 24	Month  acco use contribute to  2 ② No 3 ☐ Pro  24b. Were au prior to c death? No 1 ☐ Yes  )  acc 6 ☐ Other (Spec	the cause of death?  bably 4 □Unknown  topsy findings available completion of cause of  2 □ No
on of Vital	n. After this certificate has been signed by funeral director, page 2 should be detac	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ■ No 9 □ Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1 □ Yes 2 ■ No  27. Manner of Death	1 Live birth 2 4 Pregnant at tir 9 Unknown  ntributing to death but  Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	Fetal death me of death not resulting in th  2 ER/Outpa  28b. Tim Inju	5 ☐ Other (specify)  The underlying cause gratient 3 ☐ DOA Cape of 28c. In the part of th	26. Place of Death  26. Place of Death  Other: 4 ☐ Nursing Holiury at lork? ☐ Yes 2 ☐ No	1  Yes  24a. Was an autopsy perform 1  Yes 24  (Check only one me 5  Resider 28d. Describe how	Month  acco use contribute to  2 No 3 Pro  24b. Were au prior to a death?  No 1 Yes  co 6 Other (Special Injury occurred)	the cause of death?  babably 4 □Unknown  topsy findings available completion of cause of 2 □ No
on of Vital	n. After this certificate has been signed by funeral director, page 2 should be detac	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions condition	1 Live birth 2 4 Pregnant at tir 9 Unknown  ntributing to death but  Hospital: 1 Inpatient 28a. Date of Injury (Month, Day )	Fetal death me of death not resulting in th  2 EFVOutpa 28b. Tim Inju y - At home, farm (Specify)	atient 3 DOA Company M 11 Street, factory, office death occurred at the	26. Place of Death  26. Place of Death  Other: 4 \( \text{Nursing Ho} \)  ork?  Yes 2 \( \text{No} \)  time, date and place,	1 ☐ Yes  24a. Was an autopsy perform 1 ☐ Yes 24  (Check only one me 5 ♣ Resider 28d. Describe how city or Town, and due to the care	Month  acco use contribute to 2 No 3 Pro 24b. Were au prior to a death? No 1 Yes  Oce 6 Other (Spect and Number or Russiate)  seet and Number or Russiate)	the cause of death?  babally 4 □Unknown  topsy findings available completion of cause of 2 □ No  city)  wral Route Number,
on of Vital	nin 24 hours after death. the Funeral Director: Atter this certificate has been signed by npletely filled in by the funeral director, page 2 should be detac	To Be Completed by	25b. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions condi	Hospital: 1   Inpatient   28a. Date of Injury (Month, Day)   28e. Place of Injury building, etc.	Fetal death me of death me of death not resulting in the 2 ER/Outpar 28b. Time Injury - At home, farm (Specify)  my knowledge, death not consider the construction and/outpart in the construction of the cons	atient 3 DOA Cate of Many Many Many Market, factory, office death occurred at the prinvestigation, in my 29c. Lice	26. Place of Death  26. Place of Death  Other: 4 \( \text{Nursing Ho} \)  ork?  Yes 2 \( \text{No} \)  time, date and place,	1 Yes  24a. Was an autopsy perform 1 Yes 28  (Check only one me 5 Resider 28d. Describe how City or Town, and due to the cared at the time, da	Month  acco use contribute to 2 No 3 Pro 24b. Were au prior to a death? No 1 Yes  Oce 6 Other (Spect and Number or Russiate)  seet and Number or Russiate)	the cause of death?  bably 4 □Unknown  topsy findings available completion of cause of  2 □ No  cify)  wral Route Number,  stated, to the cause(s)
on of Vital	n. After this certificate has been signed by funeral director, page 2 should be detac	edical Certification; To Be Completed by	25b. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural sinvestigation 3 Suicide determined  29a. Certifier (Check only one)  2 Medical Examiner)	Hospital: 1   Inpatient   28a. Date of Injury (Month, Day)   28e. Place of Injury building, etc.	Fetal death me of death me of death not resulting in the control of the control o	atient 3 DOA Cate of 28c. In In In In In Inc. of Inc.	26. Place of Death Other: 4 \( \text{Nursing Ho} \) I ves 2 \( \text{No} \) Itime, date and place, or opinion, death occurrence of time in the court of the court	1 Yes  24a. Was an autopsy perform 1 Yes 28  (Check only one me 5 Resider 28d. Describe how City or Town, and due to the cared at the time, da	Month  acco use contribute to 2 No 3 Pro 24b. Were au prior to c death? No 1 Yes  oce 6 Other (Spect injury occurred)  aset and Number or Ruse(s) and manner as te and place, and due  d. Date signed (Mont)	the cause of death?  bably 4 □Unknown  topsy findings available completion of cause of  2 □ No  cify)  wral Route Number,  stated, to the cause(s)

State of Maryland / Department of Health and Mental Hygieney 32522 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 6:50 A Margaret Teresa Jackson October 1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 88 Yrs. 1918 Washington, DC Director 578-10-3439 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 □ No Leonardtown Director Mary land St. Mary's death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 usa 22680 Cedar Lane Court, Apt. 3202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 □ Yes 2 □XNo It Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3)(X) Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene. Telephone Company 12 Telephone Operator ages 1 and 2 should be filed want of Health and Mental Hygier it: if item 27 is marked other it y or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Loveless Andrew Thomas Jackson Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informant's Name/Relationship (Type, Print) 23244 Colton Point Road, Clements, MD 20624 James Jackson/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 5, 2006 Clinton, Maryland permit. Page Depertment of Important: if any injury or ang. Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signau re 1 Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P. P.O. Box 270, Leonardtown MD 20650 P. 0. Box 270 Leonardtown MD 2065

23a. Part 1. Enter the disease, or complications that ceused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardio - respiraton **Physician** /Medical Due to (or as a consequence of): Examiner thrive Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Advance demer the attending physicien and hed for use es the burial-tran Due to (or as a consequence of): Box 68760, 5 audi Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months?
1 \(\sumeq\) Yes 2 \(\sumeq\) No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknow signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificete 2 No 1 Yes of Vital Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 2 this s after death.

I Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Hospital or within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10.2.06 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. A.D. Shah St. Mary's Medical Arts Bldg. Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 3 2006

#### State of Maryland / Department of Health and Mental Hygiene 0.00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event, the Medical Examinar must be notified at once.

Kendall, Barbara

Physician /Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, -10-

	1. Decedent's Name (	ימיום א	מוקע ענ	ATT						1	Date of I	/ Day	0 - 04	3. Time of Death
	4a. Facility Name (If n		give street ar				4b. City.	Town, or I	Location of [		epter		County of De	ath
ĺ	Memo		1400	solt	, /		10.01	Enc	ton				Tolh	at
4,	5. Social Security Num 024–20–48	nber	6. Sex		e (In yrs. la	ast birthda <sub>j</sub> Yrs.	/) If Under Months		If Under 24 Hours	Hrs. 8. Min.	Date of I	Birth Day Year)	9. Bi	inthplace (State or Fore Country) MASS.
	Usual Residence of D				,,,	-					D111 1 .	,	1,40	
	10a. State 1	0b. County			10c. City	, Town or I	Location							10d. Inside City Lim
	MD	T	ALBOT			EAS'	CON					_		1 to Yes 2
-	10e. Street and Numb						10f. Zip					10g. Citi	izen of What C	
_	28539 OA	KMONT				- 1			21601	0.10				USA
	11. Marital Status	. 2□ Marsi	Arm	Decedent 6 ed Forces? Yes 2010		5. 13	If Yes, spe	dent of His cify Cuban	spanic Origin n, Mexican, P	uerto Ric	can, etc.)	No-	Black, Wh	nerican Indian, nite, etc.
	1 Never Married 3 Widowed 4	_	If Ye	s, Give r or Dates:	40		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify:	HITE
-	(Specify	only highes	's Education t grade comple			(Giv	edent's Usu re kind of wo DO NOT u	ork done di	urina most o	f working	•	16b. Ki	ind of Busines	s/Industry
	Elementary/Second	lary (0-12)	Colle	ege (1-4or 5 <b>3</b>	)+)	REA	AL EST	ATE A	GENT			1	REAL ES	TATE
	17. Father's Name (Fi	irst, Middle, I	Last)						18. Mother's	Name (F	First, Midd			
	HAROLD	BERRY							HE	LEN	SCHEI	RER		
	19a. Informant's Nam				T /DATE								or Town, State,	, Zip Code)
	KATHRYNE		TT WID	DLETO		-	C I/		ST.,	EAST Dat		_	DUL ocation - City o	y Town State
	20a. Method of Dispos 1 ☐ Burial 2 🛣 4 ☐ Donation 5	Cremation		from State	Ce	metery, cr	ematory or o	other place	ON CT					SVILLE, MD
Ì	21. Signature of Fune	ral Service I	Licensee			1	22. Name ar	nd Address	s of Facility	ETN .	s mer	THAM I	ETTATED AT	HOME PA
	JOH	.1 3	_		-									HOME IA
The state of the s	23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	disease, or failure. List	only one cause	that caused	the death ne.	. Do not e	200 S. nter the mod						21001	Approximate Interval Between Onset and Death
	23a. Part1. Enter the shock, or heart f Immediate Cause (Fi disease or condition	disease, or failure. List nal iitions, ediate	ab	that caused on each lin	the death ne. 15 a consequ a consequ	Do not e							21001	Interval Between
	23a. Part1. Enter the shock, or heart il immediate Cause (Fidisease or condition resulting in death)  Sequentially list cond if any, leading to death and the cause (Disease or in that initiated events)	disease, or failure. List nal itions, ediate ing jury st	a	that caused on each line SEPS ue to (or as ue to (or as	the deathne.  / S a consequ a consequ a consequ of pregnar 2   Fetal	Do not elence of):  sence of):  sence of):		de of dying				v arrest,	23d. Date of d Month	Initerval Between Onset and Death
	23a. Part1. Enter the shock, or heart inmediate Cause (Fit disease or condition resulting in death)  Sequentially list cond if any, leading to immorphism of the cause (Disease or injurity that initiated events resulting in death) Last IF FEMALE:  23b. Was decedent print the past 12 mr. 1 Pyes 2 mr.	disease, or failure. List nal itions, ediate ing ury st	a	that caused on each life SEPS use to (or as	Ithe deathne.  IS a conseque a conseque a conseque of pregnar 2 Fetal time of de	Do not elence of):  vence of):  vence of):  vence of):  vence of):	DEctopic p	oregnancy	, such as ca		23e. Di	d tobacco	23d. Date of d Month	Initerval Between Onset and Death
	23a. Part1. Enter the shock, or heart inmediate Cause (Fit disease or condition resulting in death)  Sequentially list cond if any, leading to immediate death (Cause (Disease or in) that initiated events resulting in death) La:  IF FEMALE:  23b. Was decedent p in the past 12 m 1	disease, or failure. List nal itions, ediate ing ury st	a	that caused on each life SEPS use to (or as	Ithe deathne.  IS a conseque a conseque a conseque of pregnar 2 Fetal time of de	Do not elence of):  vence of):  vence of):  vence of):  vence of):	DEctopic p	oregnancy	, such as ca		23e. Di 1[ 24a. W	d tobacco u	23d. Date of d Month  use contribute	elivery Day  Year  to the cause of death'  Probably 4 □Unkno
	23a. Part1. Enter the shock, or heart il mmediate Cause (Fili disease or condition resulting in death)  Sequentially list cond if any, leading to immost a filing to	disease, or failure. List nal litions, rediate ingury st	a	that caused on each life SEPS use to (or as	Ithe deathne.  IS a conseque a conseque a conseque of pregnar 2 Fetal time of de	Do not elence of):  vence of):  vence of):  vence of):  vence of):	DEctopic p	oregnancy	n in Part I.	rdiac or r	23e. Di 1[ 24a, W au pe	d tobacco u  Yes 2  as an topsy formed?  s 2 1 No	23d. Date of d Month  use contribute  No 3 1	elivery Day Year  to the cause of death Probably 4 Unknow autopsy findings availage of completion of cause
	23a. Part1. Enter the shock, or heart il mmediate Cause (Fili disease or condition resulting in death)  Sequentially list cond if any, leading to immost a state of the cause (Disease or init that initiated events resulting in death) La:  IF FEMALE: 23b. Was decedent p in the past 12 m in the pa	disease, or failure. List in al itions, ediate in gregnant onths?	a	that caused on each life SEPS ue to (or as u	the deathne.  / S a conseque a conseque a conseque of pregnar 2   Fetal time of de ut not resu	Do not elence of):  vence of):	□Ectopic p □ Other (s) underlying o	oregnancy pecify)  Cause given	n in Part I.	Death (6	23e. Di 1[ 24a. W au pe 1   Yet	d tobacco u  Yes 2  Sas an an topsy offormed?  2 19 No	23d. Date of d Month  use contribute No 3   1	elivery Day Year  to the cause of death' Probably 4 Unknowautopsy findings available occurrences and personal services and personal services and personal services are services as a service services and personal services are services as a service are services as a services are services as a service are services as a services are services as a service as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a service are services as a service are services as a services are services are services as a service are services as a ser
	23a. Part1. Enter the shock, or heart ill mmediate Cause (Fill disease or condition resulting in death)  Sequentially list cond if any, leading to immediate Sequentially list cond if any, leading to immediate Sequentially list cond if any, leading to immediate Sequentially list conditions and sequentially list conditions are sufficiently list of the sequential	disease, or failure. List in al itions, ediate in gregnant onths?	a	that caused on each life SEPS  Let to (or as the to (or as	a conseque a conseque a conseque a conseque time of definition of the conseque time of definition of the conseque time of definition of the consequent and the consequent according to the consequent	Do not elence of):  nence of):  nence of):  nence of):  nence of):  sence of):  sence of):  sence of):	Dectopic p	oregnancy pecify)  Cause given	n in Part I.  26. Place of	Death (	23e. Di 1[ 24a. W au pe 1 Ye: Check onl	d tobacco u  Yes 2  Bas an antopsy offormed?  s 2 [No y one)  ssidence	23d. Date of d Month  use contribute  No 3 1	elivery Day Year  to the cause of death' Probably 4 Unknowautopsy findings available occurrences and personal services and personal services and personal services are services as a service services and personal services are services as a service are services as a services are services as a service are services as a services are services as a service as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a service are services as a service are services as a services are services are services as a service are services as a ser
	23a. Part1. Enter the shock, or heart il immediate Cause (Fill disease or condition resulting in death)  Sequentially list cond if any, leading to immediate Cause (Disease or inj that initiated events resulting in death) La:  IF FEMALE: 23b. Was decedent p in the past 12 m 1	disease, or failure. List in al itions, ediate in gregnant onths?	a	that caused on each life SEPS ue to (or as u	a conseque a conseque a conseque a conseque time of definition of the conseque time of definition of the conseque time of definition of the consequent and the consequent according to the consequent	Do not elence of):  vence of):	Dectopic p	oregnancy pecify)  Cause gives  OA Other  OX Injury Work	n in Part I.  26. Place of	Death (cing Home	23e. Di 1[ 24a. W au pe 1 Ye: Check onl	d tobacco u  Yes 2  Bas an antopsy offormed?  s 2 [No y one)  ssidence	23d. Date of d Month  use contribute No 3   i	elivery Day Year  to the cause of death' Probably 4 Unknowautopsy findings available occurrences and personal services and personal services and personal services are services as a service services and personal services are services as a service are services as a services are services as a service are services as a services are services as a service as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a service are services as a service are services as a services are services are services as a service are services as a ser
	23a. Part1. Enter the shock, or heart il mmediate Cause (Filidisease or condition resulting in death)  Sequentially list cond if any, leading to immost a street of the cause (Disease or in) that initiated events resulting in death) La:  IF FEMALE: 23b. Was decedent p in the past 12 m in the pas	disease, or railure. List nal litions, ediate ingury st	a	that caused on each life on each life SEPS  Let to (or as the to (or as	a consequence a	Do not elence of):  lence of):	DEctopic p Other (sp underlying of	oregnancy pecify)  OA Other  OA Injury Work  1 U	n in Part I.  26. Place or  4 🗆 Nursi	Death (cing Home	23e. Di 1[ 24a. Wau pe 1 Yes Check onl 6. Describ	d tobacco ( Yes 2  as an topsy s 2 No y one) esidence e how injure	23d. Date of d Month  use contribute No 3   i	elivery Day Year  to the cause of death' Probably 4 Unknowautopsy findings available occurrences and personal services and personal services and personal services are services as a service services and personal services are services as a service are services as a services are services as a service are services as a services are services as a service as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a services are services as a service are services as a service are services as a service are services as a services are services are services as a service are services as a ser
	23a. Part1. Enter the shock, or heart il mmediate Cause (File disease or condition resulting in death)  Sequentially list cond if any, leading to immost a street of the cause (Disease or in) that initiated events resulting in death) La:  IF FEMALE: 23b. Was decedent p in the past 12 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1	disease, or railure. List nal littons, rediate ingury st littons? No litton and condition of the condition o	a	that caused on each life on each life of linjuic (Month, Da) Place of linjuic (Month, Da)  Place of linjuic (Month, Da)	a conseque	Do not elence of):  nence of):	ent 3 Do	oregnancy pecify)  OA Other 28c. Injury Work 1   Y	n in Part I.  26. Place of  4   Nursi at ?  es 2   No	Death (congress)	23e. Di 1[ 24a. W au per 1   Yes Check onl 6   S   Re d. Describ	d tobacco u  Yes 2  as an topsy riformed? s 2 No y one) esidence the how injuri	23d. Date of d Month  use contribute  No 3   i	elivery Day Year  to the cause of death  Probably 4 Unknow autopsy findings availa o completion of cause as 2 No
	23a. Part1. Enter the shock, or heart Immediate Cause (Fill disease or condition resulting in death)  Sequentially list cond if any, leading to immediate death (Cause (Disease or injulational initiated events resulting in death) La:  IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 m 9 Unknown  Part II. Other significations of the past 12 m 1 Yes 2 1 m 1	disease, or failure. List nal littons, ediate ting littons and condition of the condition o	a	that caused on each life on each life SEPS use to (or as u	a conseque	Do not elence of):  nence of):	ent 3 Do of Mathocourred investigation 29	one of dying oreginal	n in Part I.  26. Place of  4   Nursi at e, date and j inion, death	Death (c) 286	23e. Di 1[ 24a. W au pe 1   Yes Check onl city or d due to til at the tim	d tobacco u  Yes 2  as an itopsy informed?  so 2 No  y one)  esidence he how injure  (Streat arr  Town, State  the cause(s) e, date and	23d. Date of d Month  use contribute  No 3   1  24b. Were prior to death 1   Ye  6   Other (Sp. ry occurred)  and Number or a   1   1   1   1   1   1   1   1   1	elivery Day Year  to the cause of death Probably 4 Unknow autopsy findings available completion of cause as 2 No Decify)  Rural Route Number, as stated, ue to the cause(s)
	23a. Part1. Enter the shock, or heart Immediate Cause (Fill disease or condition resulting in death)  Sequentially list cond if any, leading to immediate death and interest a	disease, or failure. List in al itions, rediate in gury st in and condition on the condition of the conditio	a	that caused on each life on each life of each life of language to (or as use of language)). If of the best of the basis of the manner start of accuse of displacements.	in the death ne.  IS a conseque b graphic conseque a co	Do not elence of):  lence of):	ent 3 Do of M Street, factor ath occurred investigation 29	de of dying oregnancy poecify)  Cause given to the time of the tim	n in Part I.  26. Place of T. 4   Nursiat ?  Yes 2   No. 1   No. 2   N	Death (cong Home 28c)	23e. Di 1[ 24a. W au pe 1 Yes Check onl 5 Rd d. Describ f. Location City or	d tobacco u  Yes 2  as an itopsy informed?  so 2 No  y one)  esidence he how injure  (Streat arr  Town, State  the cause(s) e, date and	23d. Date of d Month  use contribute  No 3   1  24b. Were prior to death 1   Ye  6   Other (Sp. ry occurred  and Number or a b) and manner d place, and di tte signed (Mo	elivery Day Year  to the cause of death Probably 4 Unknow autopsy findings available completion of cause as 2 No Decify)  Rural Route Number, as stated, ue to the cause(s)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. Ne2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** September. DAVIS C. KIRBY, JR. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton albot 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 29. 1 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Yrs Director 227-01-4295 91 1914 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if itam 27 is marked other then "natural, or items 23a or 28a-f show or other traumatic event, the Medical Examination into the notified at MD TALBOT EASTON Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 501 DUTCHMANS LANE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEER LAND SURVEYING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Heelth and Menta! | Int: if itam 27 is marked o DAVIS CLARK KIRBY ADA NAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth at
important; if itam 27 is
eny injury or other trau KATHERINE K. GILSON/DAUGHTER 5419 MORGANS PT. RD., OXFORD, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 9/22/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 NHOF MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** spiration pneumonia /Medical Due to or as a consequence of Examiner severe dortic Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably Be Completed 1 ☐ Yes 2 ☐ No 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autop sv performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending death. i Director: / investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Dey, Year) LOXIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/200

State

Sarrot

Mr

2000

32. Registrar Signature

Itaider

31. Date filed (Month, Day, Year)

mend	led#20b	,	1_ For FD, TCH	D,09/27	tate of Mary	land / D	epartment Certificate	of Hea	alth and N	fental Hy	giene	006	32525	
	Physici	an	Registrar  1. Decedent's Name (First,		1./	*	Certificate	OIDE	zalii	2. Date of De	Reg. No.		3. Time of Death	_
	/Medic Examir	cal	4a. Facility Name (If not ins			ne		x 1	cation of Death	Septen		County of Deal		
	Funeral Director		5. Social Security Number 219-62-8766	6. Sex	7. Age (In	yrs. last birti	hday) If Under	Year If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt Co	hplace (State or Foreign untry) SOn, MD	n
	pu 🖈		Usual Residence of Deced	ent County	10	c. City, Town				00-20-	1994	flau1	10d. Inside City Limits	
	ith the Man or 28e-f sh	ector	MD Do	rchester		Cambi	idge	Codo			10= Citi	zen of What Co	1 XYes 2 No	-
	23e or	ai Dir	809 Hubbard	St.			216				USA	zen or what Co	untry ?	
. 980	or Items	by Funeral Director	11. Marital Status  1 Never Married 2  3 Widowed 4 XDiv	Married 1	Was Decedent Ever Armed Forces? XXYes 2 ☐ No f Yes, Give /ear or Dates:	in U.S.	13. Was Decede If Yes, speci		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: B1	e, etc.	
21215-0036	nin 72 hours n "natural", Medicul Ex.	Completed	(Specify only	cedent's Educatio	nnnpleted)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupation done durit	n ng most of work	ing	16b. Kir	nd of Business/	Industry	
121	e filed withing Hygiene. other than vant, I'm M		Elementary/Secondary (0 12 17. Father's Name (First, M		50118ge (1-401 3+)	I	ork Lift			- /Fi - A A 4 - 4 / 1		ck & De	cker	_
lanc	ed page	o Be		Russell	Le	е			Norcy	Kane	, Maiden	Sumame)		
Maryland	2 = Z		19a. Informant's Name/Rel Diane Kane/		Print)		Mailing Address (		Number or Rur Cambrid				Zip Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tre <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem `4 ☐ Donation 5 ☐ Ot		val from State	cemetery	Disposition (Name of crematory or oth Cerans Ce	ner place)	10/0	2/2006		cation - City or	Town, State	
Baltii	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral S		8			Address o	f FacilityBenr		th Fu	ineral 1	Home	_
	Pnysician /Medical		23a. Part 1. Enter the disagness shock, or hear active immediate Cause (Final disease or condition resulting in death)	ise, or complication. List only one ca	ons that caused the use on each line.  Due to (or as a co	rect	a) C	of dying, s		or respiratory a	rresf,		Approximate Interval Between Onset and Death	ĺ
0,	Examiner ician and privial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or white) that initiated events resulting in death) Last	b. —	Due to (or as a co	nsequence o	f):							
8760,	icate be e physician s the buria	dicai		d										_
O. Box 6	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	? 1	yes, outcome of pr Live birth 2 Pregnant at time Unknown	Fetal death	3 □Ectopic pre- 5 □ Other (spe				2	3d. Date of deli Month	very Day Year	
rds, P.O	quires that the signed by ald be detacted.	by	Part II. Other significant co	nditions contribu	iting to death but no	t resulting in	the underlying car	use given ir	n Part I.	23e. Did t			the cause of death?	
Division of Vital Records,	The law requir ate has been si page 2 should	Completed			-					24a. Was autoj perio		24b. Were au prior to death?	topsy findings available completion of cause of	
Vita	ysicien: Th is certificate director, pag	o Be (	25. Was case referred to mexaminer?	Hospit	tal:			Cthon	. Place of Death					
on of	tanding Phys death. tor: After this the funeral di	$\vdash$		Pending nvestigation	Ba. Date of Injury (Month, Day Yea	2 ER/Outp		c. Injury at Work?	4 Nursing Ho	me 5 □ Resi 28d. Describe			ify)	
Divisi	of attandi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 □C	Could not be	Be. Place of Injury - building, etc. (Sp	At home, fari				28f. Location ( City or Tou	Street and wn, State)	d Number or Ru	ral Route Number,	
	To the Hospitel or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one)	dicel Exeminer: (	n: To the best of my On the basis of exa and manner stated.	knowledge, mination and	death occurred at for investigation, i	the time, on my opinion	date and place, on, death occurr	and due to the ed at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of o	ertifier	4		29c.	License nu	ımber	4	29d. Date	signed (Month	n, Day, Year)	
			30. Name and address of pr	erson who comple	ted cause of death	(Item 23a) (		141	7643.		- W	ember	,	0
	⊁√/ <del>/</del> Sta	to	31. Date filed (Month, Day,	reene	32. Pagistrar's S	Gignature E	ALtimo	ee.1	MD 212	امل ای	Ken	e 0 D	giemb.	
	Registr	-	SEP	2 7 2008	Man.	M	Ren	-						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

		1 - For State Registrar		aryland / [	Departm <i>Certific</i>	ent of H	ealth an Death		Reg.	2006	32527
Physici /Medi		Decedent's Name (First, Middle, La     STEVENSON JINYOU						2. Date of Month SEPTE		Day Year 26, 2006	3. Time of Death 5:20 PM
Examir		4a. Fecility Name (If not institution, giv			4b. (		Location of D			4c. County of Dea	
Funeral Director		4525 MINUTEMAN DRI 5. Social Security Number 6. S 217-06-2995		ge (In yrs. last bir	thday) II U	nder 1 Year	VILLE If Under 24 Hours	Min. (Month	i, Day, Ye	MONTGOMEF	thplace (State or Foreign ountry)
· ·		Usual Residence of Decedent 10a. State 10b. County		26 10c. City, Tow	n or Location			JULY :	23, 19	700   11	ARYLAND  10d. Inside City Limits
r 28e-f sh	Director	MARYLAND MONTGOM  10e. Street and Number	ERY			OCKVILL . Zip Code	E		10g.	Citizen of What Co	1 ☐ Yes 2 🖾 No
ath with	raiD	4525 MINUTEMAN	· · · · · · · · · · · · · · · · · · ·				20853			U.S.A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show spingury or other traumatic event, the Medical Examiner must be multified at once.	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			ecedent of Hi specify Cuba as 2\lambda No		i? (Specify Yes o Puerto Rican, etc.	r No- .)	14. Race - Ame Black, Whit	
215-0 thin 72 ho en "natur Wedical	Completed	15. Decedent's E (Specify only highest gr.			Decedent's (Give kind o life. DO NO	Usual Occupa f work done o T use retired	turing most of	f working	16b	. Kind of Business	/Industry
Maryland 21215-0036 nd 2 should be filed within 72 hours all th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Be	17. Father's Name (First, Middle, Last	5+		STUD	DENT	18. Mother's	Name (First, Mi	ddle, Maio	EDUCATION den Sumame)	I
aryla should the mond the mond the mond Menulation to market the m	2	EDWARD Y. KIM 19a. Informant's Name/Relationship (	Type, Print)	19b	. Mailing Add	ress (Street a		KAREN K. or Rural Route N		ty or Town, State,	Zip Code)
re, Ma s 1 and 2 Health a tem 27 ls		KAREN K. KIM - M	OTHER	20b. Place of	Disposition	(Name of		ROCKVILLE,		LAND 20853 Location - City or	Town, State
L Pages 1 a riment of Heart II (16m		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	<del>(</del> y)		y, crematory MEMORI	AL PARK	9	/28/2006		OLNEY, MAR	YLAND
B Department		21. Signature of Funeral Service Licer	nsee .	ti	HINE		DI FUNER	RAL HOME, E AVENUE,		R SPRING, M	ARYLAND 20904
Physician /Medical Examiner	- Carlo	23a. Par1. Enter the disease, or com shock, or bean failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	S LYMPHON a consequence	1A	mode of dying	g, such as car	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death 4 YEARS
/ 60, te be executed ysicien and te burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence							
Geath certificate attending physod for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4 Pregnant a	2 Fetal death		ic pregnancy r (specify)				23d. Date of de Month	livery Day Year
ecords, P.O. law requires thet the as been signed by th	ρ	Part II. Other significant conditions of	contributing to death b	out not resulting in	the underlyi	ng cause give	n in Part I.				o the cause of death?
<b>≖</b> 6 6 6 8	Completed							_ a	Mas an lutopsy performed es 2 ☑	? prior to death?	utopsy findings available completion of cause of
Of VITAL He Physician: The this certificate he ral director, page	Be	25. Was case relerred to medical examiner?	Hospital:			1 DOA Othe	·-	Death (Check o			
on o	tlon: To	1 ☐ Yes 2 🔯 No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Da	ent 2 ER/Ou iry 28b. 1 y Ye <i>ar)</i> I	Time of njury	28c. Injury Work	4   Nulsii	28d. Descr		6 ☐Other (Spenjury occurred	cify)
DIVISIC tal or Attent s after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inj	ury - At home, fa c. (Specify)	rm, street, fa	ctory, office		28l. Locati City of	on (Street Town, St	and Number or R ate)	ura <i>l R</i> oute Number,
Lo the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1  Certifying Pr (Cneck only one) 2  Medical Exam	nysician: To the best miner: On the basis o and manner st	t examination an	dor investiga	rred at the tim ttion, in my op	e, date and pointion, death o	place, and due to occurred at the ti	the cause me, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	e lesse re	rep		29c. License				Date signed (Mont	
		30. Name and address of erson who CHERYL AYLESWORTH,	W:					WHEATON,		AND 20902	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Span	le					

			For State Ragistrar	State of	Marylan	•		nt of H <i>te of L</i>		and M	ental Hy	giene Reg. No	UUb	1	325	28
			1. Decedent's Name (First, Middle, Last	)							2. Date of De	ath Day	v Yea	,	3. Time of	Death
	Physici /Medio		WILLIAM	I.				KAR	R				27, 20		4:37	РМ
	Examir		4a. Facility Name (If not institution, give				4b. City	, Town, or				4c.	County of De			
			LANDOW HOUSE ASSIS			In a fair to the start of	If I lod	RO er 1 Year	CKVII If Under:		O Data of Bi	-			OMERY	. Consine
П	Funeral Director		5. Social Security Number 6. Se 358-05-3560	x ]M 2□F	7. Age (In yrs. 87	Yrs.	Months		Hours	Min.	8. Date of Bi	19 gear)	9. 6	Ch	ce (State o	IL
	ס		Usual Residence of Decedent													
	how thow	_	10a. State 10b. County			ty, Town or Lo								100	i. Inside Ci 1 ဩYes	
:	Sa-1 of	Director	MD Montgome	ry	Ro	ckvi11										2 🗆 140
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. In marked other than "naturel", or items 23e or 28e-f show aumatic event, the Madical Examiner mant be notified at	Dir	10e. Street and Number 1799 East Jefferso	n Stre	et #226			ip Code 20852				US	izen of What ( A	Countr	y?	
	ms 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.1	Was Dec	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No	0-	14. Race - Ar			
တ	or ite		1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv				ecity Cuba 24 No	n, Mexican Specify:		Rican, etc.)		Black, Wi			
8	urel',	d by	3X Widowed 4 □ Divorced	Year or Da	ites:								Specify:		ite	
2	nati	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced (Give life. Econo	tent's Us	uai Occupa rork done d	ition <i>luri</i> ng most	t of working	g		ind of Busines			
12	withir ene. than	Completed	Elementary/Secondary (0-12)	+ College (1	4or 5+)	Econo	mist	use remed	,			U	.S. Go	ver	nment	:
Maryland 21215-0036	Hygi other	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Surname)	-		
<u>a</u>	should be f and Mental h marked of umatic eve	To B	Benjamin Karr						Yett	ta Si	.1ver					
az	2 shot and N ie ma	. 4	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	er or Rura	Route Numb	er, City o	or Town, State	, Zip C	ode)	
	Heelth Heelth tem 27 other tr	1	Roger N. Karr - Sc	n	[aa	The second second second second			Brool				ersbur			78
Baltimore,	ages 1 and 2 should b nt of Heelth and Menis t: If Item 27 Ie marked y or other traumatic e		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from S	State	Place of Disponentery, crer	natory or	ame of other plac	9)	ر / 9/29	nte O.6		ocation - City . delphi			
Ē	t. Pa rtmen rtant: njury		4 Donation 5 □Other (Specify)		PIL	Lebano			i					עניו		
BE/	perfinit. Pages Depertment of H Important: If Its eny Injury or of once.		21. Signature of Funeral Service Licens	88			WARD	SAGE	L FUN	ERAL	DIREC	TION	, INC.		- 222	
7			23a. Part1. Enter the disease, or compl	ications that ca	used the deat	th. Do not ent							, MARY		D 208 Approximate Interval Bet	
			shock, or heart failure. List only o Immediate Cause (Final			de Des		- 0							nterval Bet Onset and (	ween Death
	/Medical		disease or condition resulting in death)	d	etastat orasaconsec		stat	e Can	cer					+		
	Examiner		Convention list annulations	h												
	v =	Iner	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury	Due to (	uras a dunsik	juence of)-										
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /	or as a consec											
8760,	icien burial	a E		000 (0 (	or as a consec	idence or).										
687	ficate be executed physicien and is the burial-transit	dical		d										la		
×	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, out									23d. Date of	delivery	,	
P.O. Box	death e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	nth 2 ∐Feta antat time of o		JEctopic Other (	pregnancy s <i>pecify)</i>					Month	D	ay ^	Year
0	at the by th stache	hys	9 Unknown	9□ Unkno												
<u>ග</u>	The law requires that the death certificate be executed are thes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II. Dther significant conditions co Atrial Fibrilla		ath but not res	sulting in the u	nderlying	cause give	en in Part I.				use contribute			
ord	w requir been s should	ted	Depression									Yes 2	T		oly 4 □t	
Sec.	e taw hes b 3e 2 st	Completed									24a. Was		24b. Were prior t death	autops o com	y findings pletion of c	available ause of
<u></u>	Physicien: The ta r this certificate her aral director, page 2										1 Tes	2 X No	1 □ Y	es 2	₩ No	
₹ ;	certif	Be c	25. Was case referred to medical examiner?  1 Yes 2 XNo	Hospital:	npatient 2	ER/Outpatier	nt 3□ [	Othe			(Check only		6 <b>X</b> ]Other (S		SSIS	TED)
Division of Vital Records,	a Phy er this eral d	n: To	27. Manner of Death		nf Injury h, Day Year)	28b. Time of		28c. Injury Work	4 🗀 Nu		8d. Describe			oecny)	LVING	
<u></u>	nding Path. Ith. It: After I	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mont	n, Day Year)	Injury	М		<br Yes 2 □	No						
N N	t or Attend after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At h	ome, farm, str	eet, facto	ory, office		2	8f. Location City or To	Street ar	nd Number or	Rural	Route Num	iber,
ਠ <sub>:</sub>	Itel or ral Di led in	Cer		1	9, (-,						,					
	Hosp 14 hou Fune tely fil	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ner: On the ba	sis of examina	owledge, death ation and/or in	n occurre vestigation	d at the tim on, in my of	ne, date an pinion, dea	nd place, a oth occurre	ind due to the ed at the time	cause(s date and	) and manner d place, and d	as sta ue to t	ted. he cause(s	s)
	o the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director;	Med	one) 29b. Signature and title of certifier	and manr	er stated.		2	9c. License	number			29d. Da	te signed (Mo	onth, D	ay, Year)	
	F ≱ F 8		Do O Col	un	L	10		02036					PTEMBEI			06
-	20			ompleted caus	e of death (Ites	n 23a) (Type	Print)								,	
		1	Joel Kalman MD			139	96 P	ICCAR	D DRI	VE,	ROCKVI	LLE,	MARYL	AND	208.	50
N.	Sta		31. Date filed (Month, Day, Year)		gistrar's Sign	ature	ASE)	4 9								
	Registi	di	SEP 2.9 204	JU MAN	2000 6											

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Maryland		ent of Health and ate of Death		iene ig. No A A A A	3252
Physici /Medic		Decedent's Name (First, Middle, Last)     April Ann Lowe				2. Date of Deat Month Septembe	Day Year 27 25 2006	
Examin Funeral Director	er	216-96-5266	spital	В	altimore Cit der 1 Year   If Under 24 F S   Days   Hours   M	y Y	4c. County of Deat  4c. County of Deat  9. Birt  Co	h hplace (State or Fore untry) ington DC
how how		Usuaf Residence of Decedent  10a. State 10b. County		, Town or Location				10d. Inside City Lim
ith the mar or 28a-fe	Director	Maryland Anne Arun  10e. Street and Number  1724 Greentree Cou			Zip Code 21114		0g. Citizen of What Co	
De liled within 72 nouts after death with frie maryland fial Hygiene. do other than "natural", or Itams 23a or 28a-f ehow event, the Moulcal Examinar most be notified at	Funeral		12. Was Decedent Ever in U. Armed Forces? 1	S. 13. Was De	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu s 2⊠ No Specify:		14. Race - Ame Black, Whit	ncan Indian, e, etc.
William Communication of the Madical Ex	Completed by	(Specify only highest grade	cation		Isual Occupation work done during most of to see retired)  Specialist	working	16b. Kind of Business	
and Menfal Hygiene. is marked other than aumatic event, tre M	To Be C	17. Father's Name (First, Middle, Last) Woodland Eugene Co	ox. Sr.	OUNCELLEC	18. Mother's f	Name (First, Middle, M		
and Men is marke	Ĕ	19a. Informant's Name/Relationship (Ty			ess (Street and Number or	Rural Route Number	, City or Town, State,	Zip Code)
agos I and 2 should and Men tit if Item 27 is marke y or other traumatic		Richard E. Lowe / 20a. Method of Disposition 1 Burial 2 **Cremation 3 B 4 Donation 5 Other (Specify)	emoval from State	lace of Disposition ( emetery, crematory	entree Court Name of or other place) chols Cre 10	Date	, Maryland <sup>20c. Location - City</sup> or Charlotte F	Town, State
Department of H Important: if Ite any injury or of		21. Signature of Funeral Service License  Kyle S. Simons	of the S	22. Name	and Address of Facility sfield-Echol Box 128 Char			
hysician //Medical bhysician and property steps the private transit steps to the private transit steps	edicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Anoxic Brai Due to (or as a consequence of the cons	n Injury uence of): est uence of):				friterval Between Onset and Death 7 days 7 days
iffending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 Ectop	c pregnancy (specify)	60	23d. Date of de Month	livery Day Year
n signed by the a	b	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	ng cause given in Part I.		bacco use contribute to	the cause of death
certificafe has been si rector, page 2 should	Completed					24a. Was a autops perform	sy prior to med? death? 2∑No 1 ☐ Yes	utopsy findings avai completion of cause 2 \( \text{No} \)
Affer this funeral d	tion: To Be	27. Manner of Death 1 X Natural 5 ☐ Pending	lospitaf: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	Other		ence 6 Other (Spe	ocify)
within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fac y)		28f. Location (SI City or Town	treet and Number or R n, State)	ural Route Number,
within 24 hours of To the Funeral I completely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno nor: On the bests of examina and manner stated.	wledge, death occur tion and/or investiga				
withi To the	Σ	29b. Signature and title a differ	_/		29c. License number D0063212		9d. Date signed (Mon	
		30. Name and address of person who co					September 3	2000

	an	1. Decedent's Name (First, Middle, Las	11.000				2. Date of De Month Sept. 2	Dav Ye	3. Time of Death 12:25 A
/Medic	al	4a. Facility Name (If not institution, give	a street and number)		4b. City, Town, or L	ocation of Dea		4c. County of D	
Examir	ier	Montgomery Genera			Olne			Montgo	mery
ineral rector		5. Social Security Number 147–07–9016 6. So	ex. 7. Aga (In yi	rs. last birthday, Yrs.	Months Days	If Under 24 Hr. Hours Mir		<sup>th</sup> 1915 Ne	Birthplace (State or Fore
¥		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Lim
finds	tor	MD Montgome	ery	Rockv	ille				1 🖾 Yes 2 🗆
s or 28e Le noti	Director	10e. Street and Number 13507 Turkey Brance	h Denkriesi		10f. Zip Code	853		10g. Citizen of Wha	•
ne 23.	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of His If Yes, specify Cuban		Specify Yes or No	14. Race - A	American Indian,
od other than "natural", or items 23a or 28e-f show event, the Medical Executar roual be notified at	þ	1 ☐ Never Married 2 【※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1.2XYes 2 □ No A If Yes, Give Year or Dates: WWI	rmy		, Mexican, Pue Specify:	nto Rican, etc.)		White, etc. White
natur deal	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupat kind of work done du	ring most of w	orking	16b. Kind of Busine	ess/Industry Note1/Restau
than	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)	0wne	DO NOT use retired)			,	Outfitting I
ent, II	Be Co	17. Father's Name (First, Middle, Last)			1	18. Mother's Na		, Maiden Sumame)	
is marked other than sumatic event, the Ms	To B	David Littman	1			Ann		(unknown)	
Item 27 is marke other treumatic		19a. Informant's Name/Relationship ( Doris Littman /		19b. Mail 1350	ing Address <i>(Street an</i> 7 <b>Tur</b> key F	od Number or F Branch	Rurai Route Numb Parhway,	er, City or Town Sta Rockville	e, MD 20853
If Item 27 or other tr		20a. Method of Disposition	1	o. Place of Disp	osition (Name of ematory or other place)	,	Date	20c. Location - City	y or Town, State
ant: If It ary or o		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State Ki		d Memorial		t.29, 20	06 Falls (	Church, VA
Important: I any njury o once		21. Signature of Ameril Certice Licen		2	2. Name and Address 2.54 CArroll	of Facility T	orchinsk NW , Was	y Hebrew hington,	Euner <b>al</b> l Hom
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	dications that caused the de one cause on each line.	eath. Do not en	ter the mode of dying,	, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	· Respire	Hom	failure				Onset and Death
edical miner		resulting in death)	Due to (or as a cons	sequence of).	00.0			1	Oversiles
	ē	Sequentially list conditions, if any leading to immediate	Due to ( r as a cons	sequence of):	home	. VVQ	n /	11/	T DUT COY
	=	in diriy, roading to intitudate							
ransit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Orophar	MAGOS	angerth.	MID	- M.	CAL EXAMINER	Ten day
cien and ourial-transit	I Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Oue to (or s a cons		adjepto	CICATION -	APPOX ED SYNTS	CAI EXAMINER	Ten day
physicien and s the burial-transit		that initiated events			712/10	CERTIFICATION	APP X + D × 1+T >	CAL EXAMINER	Ten day
nding physicien and use as the burial-transit		resulting in death) Last	Due to (or s a cons d. 23c. If yes, outcome of preg	se ence of):		CIA	APP × D	CAL EXAMINER  23d. Date o	Ten day
ettending p for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or s a cons	se ence of): gnancy etal death 31	Ectopic pregnancy Other (specify)	ACIA CERTIFICATION	APP D TO		Ten day.  I delivery  Day  Year
ed by the ettending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or s a cons d.  23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregnancy □ Other (specify)		<b>P</b> PP	23d. Date o Month	Day Year
igned by the ettending p be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or s a cons d.  23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregnancy □ Other (specify)		23e. Did	23d. Date o Month tobacco use contribu	Day Year
been signed by the ettending p should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or s a cons d.  23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregnancy □ Other (specify)		23e. Did 1	23d. Date or Month tobacco use contribu	Day Year  Ite to the cause of death Probably 4 Queknore autopsy findings availa
as been signed by the ettending p 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or s a cons d.  23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregnancy □ Other (specify)		23e. Did 1 1	23d. Date or Month tobacco use contribu  Yes 2 \sum No 3 [  an psy prior or dear	Day Year  ite to the cause of death  Probably 4 DUAK  re autopsy findings avail
as been signed by the ettending p 2 should be detached for use as	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions of the	Due to (or s a cons. d.  23c. If yes, outcome of pres. 1 Live birth 2 F.4 Pregnant at time of 9 Unknown ontributing to death but not the contributing to death but not the contribution of	gnancy etal death 3 of death 5	□Ectopic pregnancy □ Other (specify) underlying cause given	n in Part I.	23e. Did 1 1 □ 24a. Was auto	23d. Date or Month tobacco use contribu Yes 2 \( \sum \) No 3 [ an psy proper or Month of the contribution	Day Year  Ite to the cause of death Probably 4 DURK  re autopsy findings avail r to completion of cause th?
this certificete has been signed by the ettending p el director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions of the past 12 months?  25. Was case referred to medical examiner?  1 Yes 2 No	Due to (or s a cons d.  23c. If yes, outcome of prediction in a construction of the co	gnancy etal death 3i of death 5i resulting in the i	□Ectopic pregnancy □ Other (specify)  underlying cause giver	26. Place of D	23e. Did to the control of the contr	23d. Date or Month  tobacco use contribu  Yes 2 \( \sum \) No 3 (  i.a. 24b. Wer proprodea;  production one)  idence 6 \( \sum \) Other (	Day Year  ite to the cause of death Probably 4 Dukkn re autopsy findings avail r to completion of cause th? Yes 2 No
ifer this certificate has been signed by the ettending prineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of SWAS case referred to medical examiner? 1  Yes 2 No 9 Yes No 9 Unknown	Due to (or s a cons d.  23c. If yes, outcome of pree 1 Live birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not of  Hospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year,	gnancy etal death 31 of death 5 (	Dectopic pregnancy Other (specify)  underlying cause giver  of 28c. Injury Work	26. Place of D	23e. Did 1 1 24a. Was auto perfici 1 Yes eath (Check only Home 5 Resi	23d. Date or Month  tobacco use contribu  Yes 2 \( \sigma \) No 3 {\( \text{impsy} \) prior deal one)  idence 6 \( \sigma \) Other ( how injury occurred	Day Year  ite to the cause of death Probably 4 QUARN  re autopsy findings avail r to completion of cause th? Yes 2 \( \frac{1}{2} \) No
ifer this certificate has been signed by the ettending prineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or s a cons d.  23c. If yes, outcome of predictions of the second of the secon	gnancy etal death 3i of death 5i resulting in the resulti	DECtopic pregnancy  Other (specify)  underlying cause giver  of 28c. Injury Work  1 Ty	n in Part I.  26. Place of D  7. 4 □ Nursing at ?	23e. Did 1 1 24a. Was auto perficience of the control of the contr	23d. Date or Month  tobacco use contribut  Yes 2 \( \text{No} \) 3 [  an psy or prior deat of the prior one)  idence 6 \( \text{Other (} \) thow injury occurred one one of the fall  Street and Number of the prior of the prior one of the prior one of the prior one of the prior o	Day Year  Day Year  The to the cause of death Probably 4 DLakn  The autopsy findings avail In to completion of cause th? Yes 2 No  Specify)
ifer this certificate has been signed by the ettending prineral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or s a cons d.  23c. If yes, outcome of pret 1 Live birth 2 F 4 Pregnant at time of 9 Unknown  ontributing to death but not of  28a. Date of Injury (Month, Day Year 09/13/2006 28e. Place of Injury Abuilding, etc. (Specials: To the best of my ininer: On the basis of examples)	gnancy etal death 3  of death 5  resulting in the control of the c	Other (specify)  underlying cause giver  of 28c. Injury Work?  Darm 1   Year  th occurred at the time	26. Place of D  4 \( \text{Nursing} \) at es 2 \( \text{X} \) No	23e. Did to the control of the contr	23d. Date or Month  tobacco use contribut  Yes 2 \( \text{No} \) No 3 [ an psy property of the contribut on of the co	Day Year  Ite to the cause of death Probably 4 Queker  re autopsy findings avail r to completion of cause th? Yes 2 No  (Specify)  Or Rural Route Number, nch Parkway er as stated.
ifer this certificate has been signed by the ettending prineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or s a cons d.  23c. If yes, outcome of prediction of the construction of the	gnancy etal death 3  of death 5  resulting in the control of the c	Other (specify)  underlying cause giver  of 28c. Injury Work?  Darm 1   Year  th occurred at the time	26. Place of D  4 \( \text{Nursing} \) at es 2 \( \text{N} \text{No} \)	23e. Did to the control of the contr	23d. Date or Month  tobacco use contribut  Yes 2 \( \text{No} \) 3 [  an prior deal 1    one)  idence 6 \( \text{Other (how injury occurred} \)  ole fall  Street and Number of the course of the cour	Day Year  Interest to the cause of death Probably 4 Ulpknore autopsy findings available for completion of cause th? Yes 2 No  (Specify)  Or Rural Route Number,  The Parkway  or as stated. If due to the cause(s)
this certificete has been signed by the ettending p el director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or s a cons d.  23c. If yes, outcome of pret 1 Live birth 2 F 4 Pregnant at time of 9 Unknown  ontributing to death but not of  28a. Date of Injury (Month, Day Year 09/13/2006 28e. Place of Injury Abuilding, etc. (Specials: To the best of my ininer: On the basis of examples)	gnancy etal death 3  of death 5  resulting in the control of the c	Other (specify)  underlying cause giver  of 28c. Injury Work  or 1 Y  treet, factory, office  th occurred at the time nvestigation, in my opi  29c. License	26. Place of D  7. 4 \( \to \) Nursing at es 2 \( \to \) No e, date and plainion, death oc number	23e. Did 1 1 24a. Was auto perficience of the control of the control of the control of the coursed at the time,	23d. Date or Month  tobacco use contribut  Yes 2 \( \text{No} \) 3 [  an psy prior deal one)  idence 6 \( \text{Other} \) (  how injury occurred one)  1 (Street and Number of the fall of	Day Year  Day Year  Ite to the cause of death' Probably 4 Ulpknore autopsy findings availate to completion of cause th? Yes 2 U-No  Or Rural Route Number, anch Parkway  er as stated. If due to the cause(s)
ifer this certificate has been signed by the ettending prineral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or s a cons d.  23c. If yes, outcome of pretable to the pregnant at time of the policy of the prediction of	gnancy etal death 3i of death 5i resulting in the resulti	Other (specify)  underlying cause giver  of 28c. Injury Work  or 1 Y  treet, factory, office  th occurred at the time nvestigation, in my opi  29c. License	26. Place of D  7. 4 \( \to \) Nursing at es 2 \( \to \) No e, date and plainion, death oc number	23e. Did 1 1 24a. Was auto perficience of the control of the control of the control of the coursed at the time,	23d. Date or Month  tobacco use contribut  Yes 2 \( \text{No} \) 3 [  an psy prior deal one)  idence 6 \( \text{Other} \) (  how injury occurred one)  1 (Street and Number of the fall of	Day Year  Interest to the cause of death Probably 4 Llaker  The autopsy findings avail Into completion of cause Into Comp

			1- State Registrar Amend Items	States Maryland	E,686	50 10 127 tificate of L	<b>South</b> and Death		iene g. N2 0 0 6	32531
P	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi		ISSAC MOORE					09	23 2006	19:10 PM
	Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or		ath	4c. County of Death	
	F		PRINCE GEORGE'S HOS  5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	CHEVE	RLY If Under 24 H	rs. 8. Date of Birth	PRINCE G	
	<ul><li>Funeral</li><li>Director</li></ul>			M 2□F 82	Yrs.	Months Days	Hours Mi		Year) Court	lace (State or Foreign try) NTONIO, TEX
	D.		Usual Residence of Decedent					11/1.0/1	JZJ PAN A	VIONIO, ILA
	anylar	_	10a. State 10b. County  MD PRINCE GI	EORGE'S 10c. City, 7					1	0d. Inside City Limits
	Ba-f	Director	-1121.02 03	CAP.	LIOL	HEIGHTS				1 🗖 Yes 2 🗆 No
	with t	ā	10e. Street and Number			10f. Zip Code			0g. Citizen of What Coun	
	leath	Funeral	5410 ABDUL ST.	2. Was Decedent Ever in U.S.	13 1	20743			UNITED STAT	
"	r Iten	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 21 No	13. 4	Yes, specify Cubai	n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Black, White,	
93	eal, o	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes 25tNo	Specify:		Specify: BLA	CK
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28a-f show event, its Medicul Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation 1		lent's Usual Occupa kind of work done d		orkina	16b. Kind of Business/Inc	lustry
121	within ene. then "	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)	lite E	OO NOT use retired)		og		
	filed v Hygie ther t		12th 17. Father's Name (First, Middle, Last)		ACIL.	ITIES ENG			MAINTENANO	CE
Maryland	should be filed within and Mental Hygiene. marked other then imatic event, it a Mi	Be c	JOHNSON MOORE					ame <i>(First, Middle, N</i> LE CRAIG	Maiden Sumame)	
Z	2 should and Men Is marke sumatic	ှင	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	g Address (Street a			City or Town, State, Zip	Codel
	C1 C0 20 E8		VICTORIA MOORE/DAU						ASHINGTON, 1	
Baltimore,	es 1 and of Health fitem 27		20a. Method of Disposition	nam	e of Dispos	sition (Name of natory or other place	1 (	Date 2	20c. Location - City or To	wn, State
Ë	Pag nent ant: I		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	movar nom State		EMORIAL P.		/2/06	LANDOVER, N	4D
alt	permit. Departm Imports eny inju		21. Signatu e of Funeral Service L.C. nser	2 1/00	Lanca de la	Name and Address			PITOL MORTU	ARY INC.
_	<u>v</u> ∪ = 9		many	mon face				·	SHINGTON, D	.C. 20002
			23a. Parti. Enter the disease or complic shock, or heart failure. List only one	ations that caused the death. (a cause on each line.					est,	Approximate Interval Between Onset and Death
1.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	561		c S	HOC	K		Onset and Death
E	Examiner			Due to (or as a consequen	CO OI):	1001	A			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen						
	cuted nd ransit	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	M	UKF	-RAC	-14RI	6	
oʻ	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of);					
68760,	cate b	dlcal	d.						1	
-			IF FEMALE:	a If you cutcome of erogeness			$\overline{}$	/	TYAMINER	
Вох	leath certific attending p	clan	in the past 12 months?	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)		NI DOROVED BY	MEDICAID Oate of delive	y Day Year
P.O.	that the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	, ,,,	Otter (specify)	CERTIF	CATION APPLICA	MEDICAME EXAMINER Month	
	law requires that the death certif as been signed by the attending 2 should be detached for use a.	by Pi	Part II. Other significant conditions conti	abuting to death but not resulting	g in the un	derlying cause give			acco use contribute to th	
Division of Vital Records,	w require been sig should b							1 🗆 Yes	s 2 □ No 3 □ Proba	ably 4 Nunknown
ဝင	e law requ has been je 2 shoul	Completed						24a. Was an		sy findings available
<u>س</u>	ate The	Con						autopsy perform 1 Tes 2	ed? death? □XNo 1 □ Yes	npletion of cause ol 2.⊡ <b>MW</b>
/ita	Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner?		7/			eath Check only one		
of	\$ S D	2	1 163 2 100			3 DOA Other	4 U Nursing		nce 6 Other (Specify	)
Ö	ding h. After funer	tlon	27. Manner of Death  Tanatoral 5 ☐ Pending  27. Accident investigation	(Month, Day Year)	D. Time of Injury	28c. Injury Work	at ) es 2 <b>∑</b> No	Subject		
/isi	Atten r deal octor: y the	flca	3 Suicide 6 Could not be	08/25/06 T	Inknov farm, stre	ATT	2 2 110		eet and Number or Rural	Route Number
á	s afte	Certification;	4 Homicide	building, etc. (Specify)  Home		-,,		City or Town.	St.,Capi	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physic	ion: To the best of my knowled	iga, daalli	occurred at the time	, date and plac	9 300 000 000 000		
	the H tin 24 the F the F	edical	one)	r: On the basis of examination and manner stated.	and/or inve	estigation, in my opi	nion, death occ	urred at the time, da	te and place, and due to	the cause(s)
	To the Within To the comple	Σ	29b. Signature and title of centriler//	LLN		29c. License	number	29	d. Date signed (Month, D	Day, Year)
1	2		" " " " " " " " " " " " " " " " " " "	MU		00	0655	00	04,23,2	006
6			30. Name and address of person who com	pleted cause of death (Item 23)	a) (Type, P	Wal Dr	wer C	herry	09,23,2 ,MD20	785
	Sta Registr		31. Date liled (Month, Day, Year) 0CT 1 2 2006	32. Registrar's Signature	perte	A				

			1 - For State Registrar	State	of Mary	land / De	partme ertifica			ind Me	ental Hy	giene	2006		32532
	10		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath			3. Time of Death
	Physici /Medio		Stella Met	os							Septem	iber	27,200	6	12:05pm M
	Examin		4a. Facility Name (If not institution				1		Location of	Death		4c.	County of Dea		
			Shady Grove A					ockvi ler 1 Year	lle	24 Hrs. I	0 0-11 Di-	45	Montgo		
	Funeral Director		5. Social Security Number 318–24–5699	6. Sex 1 ☐ M 2 ☐ XF	100	n yrs. last birthd 83 Yrs	Month		Hours	Min.	8. Date of Bir Month, Da June 2	n Ya Year)	123 If	tnpia gu <i>ntr</i> j	ce (State or Foreign () 10 <b>1</b> S
	ס		Usual Residence of Decedent	1								,			
	urylan show	_	MD Mont			oc. City, Town or Gaither								100	I. Inside City Limits  1  Yes 2  No
	Sa-f	Director		gomery		Garther								<u></u>	
	with t	Dir	10e. Street and Number 9701 Fields R	a #1607				Zip Code 0878				_	zen of What C ced Sta		
	Jeath Jeath	by Funeral	11. Marital Status	12. Was D	ecedent Eve	rin U.S. 1			ispanic Orig	gin? (Spec	cify Yes or No lican, etc.)		14. Race - Am	erican	Indian,
9	or the	Ē	1 Never Married 2 Mar	ned 1 ☐ Ye	Forces?			pecify Cuba 2X No	in, Mexican, Specify:	, Puerto R	lican, etc.)		Black, Whi	te, et	2.
003	urel',	d by	3 XWidowed 4 ☐ Divorced	Year o	r Dates:									hit	
15-	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or fleme 23e or 28e-f ehow ent, the Medical Examinat must be notitled at	Completed	15. Deceder (Specify only highe	it's Education st grade complete	nd)	16a. De	ive kind of	sual Occup work done i	ation du <i>ring most</i> f)	of workin	g	16b. Ki	nd of Business	/Indu	stry
12	l withii iene. r than	omp	Elementary/Secondary (0-12)	Cotlege	9 (1-4or 5+)			maker				Но	ome		
פַ	e filed Il Hyg other	BeC	17. Father's Name (First, Middle,	Last)							(First, Middle				
<u>ylar</u>	Mente Mente arked	To	Sam Glavas						Con	stant	ia And	lrout	sos		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "naturel," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Constance Kas		Daught		ailing Addre	ss <i>(Street :</i> 1smea	and Numbe d Way	r or Rural , Rock	Route Numb	er, City o	r Town, State, 20854	Zip C	ode)
Je,	ttem		20a. Method of Disposition			20b. Place of Di	sposition (A	iame of	(a)	Da	ite	20c. Lo	ocation - City or	Tow	n, State
Ē	Page nent c		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		m State	Parklaw				10-2-	-06	Roo	ckville	, MI	
Baltimore,	Departr Departr Imports eny inje		21. Signature of Funeral Service	Licensee							's Soi		NC ington	DC.	20016
			23a. Party Enter the disease, o	complications that	at caused the	death. Do not		_					LIIGLOII	A	approximate nterval Between
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition			ive Hea	rt Fo	iluro							Inset and Death
1	/Medical		resulting in death)			onsequence of):	IL Fa	TTULE							
	Examiner		Sequentially list conditions,	b	-										
	led Islt	nine	Sequentially list conditions, if any leading to innecessary cause. Enter Underlying Cause (Disease or injury	Due	to por as a ce	ons cuence of									
	al-tran	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a co	onsequence of):							-	_	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		d											
68	ng phy as th	0	IS SELVING.											1	
30X	that the death certific ed by the attending p detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 typonths?	1 🗆 Liv		Fetal death	3 □Ectopic	pregnancy					23d. Date of de Month		ay Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at tim known	e of death	5 Other	(specify)					WOTE		uy . out
٥.	that the	/ Ph	Part II. Other significant conditi	ons contributing to	death but n	ot resulting in th	e underlyin	g cause giv	en in Part I.		23e. Did t	tobacco u	ise contribute t	o the	cause of death?
rds	n sign	Q D	Small Cell Lu	ng Carin	oma,Me	tastasi	S				10	Yes 2	□No 3□P	robat	oly 4 <b>X</b> Unknown
00	aw requir s been si 2 should	piet									24a. Was		24b. Were a	utops	y findings available detion of cause of
ĕ	The I	Completed									auto perfo	psy ormoned? 2 ☐ No	death?		
/ita	hysicien: The law his certilicate has l I director, page 2 s	Be (	25. Was case referred to medica examiner?	_						of Death	(Check only	опе)			
6	Physi this c	2	1 Yes 2 No			2 ☐ ER/Outpa 28b. Tim			4 🗆 1401		e 5 Resi	-	6 Other (Spe	ecify)	
o	Attending Physicism: r death. sctor: After this certifici y the funeral director, i	tion	1 ☐Natural 5 ☐ Pendir 2 ☐ Accident investi	.9	te of Injury lonth, Day Ye	ear) Inju		28c. Injur Wor	k? Yes 2⊟1		ou. Describe	TIOW III(di	y occurred		
Division of Vital Records, P.O. Box	or Attention for deal	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Pte	ace of Injury itding, etc. (3	- At home, farm, Specify)		ory, office		2	8f. Location ( City or To	Street an	d Number or F	Rural F	Route Number,
	pital o		29a. Certifier 1 Certifyin	na Physicis - T	the k	lea and - d	a a th			el alicio	and also a second				
	To the Mospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical one)	ng Physician: To Examinar: On the and m	the best of me basis of ex anner stated	amination and/o	r investigati	on, in my o	ne, date and pinion, deat	d place, as th occurre	nd due to the d at the time,	date and	and manner a I place, and du	e to th	ed. ne cause(s)
	To t Com	Σ	29b. Signature and title of certifie	111				29c. Licens					te signed (Mon tember		
1	D			you				D2133	94			ьер	Lember	41	, 2000
,			30. Name and address of person Daniel J. Go	oldbey, M	L.D. 1	h (Item 23a) (Ty 5225 Sha	oe, Print) ady Gr	ove I	Rd,Roc	kvil	le,MD	2085	0		
	Sta Registr		31. Date filed (Month, Day, Year,	9 2006	egistrar's	Signature	doart	20							

State of Maryland / Department of Health and Mental Hygiene 32533 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 09/22/2006 Year Muriel E. Miller 8:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year 8/27/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F 470-20-4622 83 Director Minnasota Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow other traumatic event, the Mudical Exactiner must be putified at 1 Yes 2 No Director MT Anne Arundel Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 43 W. McKinsey Road 21146 or Iteme 238 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status ifiled within 72 hours after di Hygiene. other then "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Dept. of Defense Pages t and 2 should be filed vent of Health and Mental Hygie ant: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hanuula Hilma Pruuki 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Depertment of Health a Important: If item 27 Ia any injury or other trau once. Mary Jo Richards (Daughter) 327 Prospect Bay Dr. W. Grasonville, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mtro Crematory 4 Donation 5 Other (Specify) 9/25/2006 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty FuneralHome PA 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athero JC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner asana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Wasan cete hes t autopsy performed? certificete 2 No 1 Yes : After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D22507 9-23-2006 use of deam (rem 23a) Type, Print) 2002 Medical Parkway Annapolis,MD 21401 Elizabeth M. Kingsley 31. Date filed (Month, Da Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Maryland	-	artment of latificate of			-	giene 0	06	32534
•			Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
	Physici		Robert Be	rnard	Norri	s, Sr	• •			Septemb	er 30,	2006	2:45 a.m.
	/Medio Examir		4a. Facility Name (If not institution,				4b. City, Town,	or Location	n of Death			ty of Death	
			St. Mary's Hos	pital			Le	onar	dtown	1		St. Ma	ary's
	Funeral			5. Sex 1∭XM 2□ F	7. Age (In yrs. la	,,	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		215-36-4100 Usual Residence of Decedent	TOM ZUF	73	Yrs.				June 17	, 1933	Mary	land
	land M		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Many	ţ	Maryland St.	Mary's			Hollywoo	ρď					1 ☐ Yes 🏖 No
	r 28a	irec	10e. Street and Number				10f. Zip Code	<u> </u>			10g. Citizen of	f What Cou	ntry?
	deeth with the Maryland me 23a or 28a-1 ehow rmust be notified at	Funeral Director	43055 St. John	's Road			20	636			Unite	d Stat	es
	ee a dee	ıner	11. Marital Status	Armed Fo		. 13. \	Was Decedent of I	Hispanic C	Origin? (Sp	ecify Yes or No Rican, etc.)	)- 14. Ra BI	ace - Americack, White.	
9	s afte	by Fu	1 Never Married 2 Marrie	If Yes, Gir	/8		1 ☐ Yes 2 🛣 No					ify: Wh:	ite
Ö	hour: tural'	d be	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or D	ates:	16a Decer	ient's Usual Occu	nation			16b. Kind of	Buein acc/In	duetny
ري زي	in 72 na r	Completed	(Specify only highest	grade completed)	1.15.	(Give	kind of work done	during m	ost of work	ring	TOD. KING OF	Dusinessin	dustry
75	y with	E O	Elementary/Secondary (0-12)	. College (	1-40r 5+)		Equipmen	it Op	erato	r	State 1	Highwa	ay Admin.
2	e file at Hy othe vent,	Bec	17. Father's Name (First, Middle, L	ast)				18. Mot	ther's Nam	e (First, Middle	, Maiden Suma	ame)	
<u> </u>	Ments	2	William Richle	y Norris					Mary	Catheri	ine Abe	11	
Maryland 21215-0036	2 sho and is m	3	19a. Informant's Name/Relationship	p (Type, Print)			g Address (Stree						
4	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene with the standard is marked other tran "natural", or itema 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at		Helen Gertrude 20a. Method of Disposition	Norris /			St. John	's R		Hollywo	od, Ma:		
Raltimore	Pages 1 nent of H int: If Its		1 🔀 Burial 2 ☐ Cremation		State Ce.	metery, cren	natory`or other pla						
<u>.</u>	it. Pa intmer intent injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Euneral Service 1		St.		s Cemete . Name and Addre						Maryland
ď	permit. Pages Department of fi Important: If Its any injury or of	F ()	Edward N. Blins	D1/. )	. M000								20650 <b>-</b> 0279
			23a. Part1. Enter the disease, or o	omplications that of	aused the death.							. 110	Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final	nry one cause on e									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	or as a conseque								· cog
	Examiner		Conventinity list conditions	b									
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ence of):							
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ance of):							
8760	ficate be executed in the physicien and streets the burial-transit	a E		00010	(or as a consequ	31109 01).							
687	ficate physics the t	edicai		d									
SC.		Ž	IF FEMALE: 23b. Was decedent pregnant		come of pregnan						23d. D	ate of deliv	ery
7 6	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregr	oirth 2 D Fetal ant at time of de		]Ectopic pregnand ] Other <i>(specify)</i> _	у			N.	<b>M</b> onth	Day Year
0	tt the d by the tached	hys	9 🗆 Unknown	9□ Unkn	own							~	
S C	- <u>2</u> - 2 - 2	by P	Part II. Other significant condition	s contributing to d	eath but not resul	ting in the u	nderlying cause gi	ven in Par	t I.	23e. Did 1	/		he cause of death?
Co Pro	w requir been si should	ted	Congestive L	eur f	<u>selupe</u>					10	Yes 2. Mo	3 ☐ Prot	oably 4 🗍 Unknown
Bernard Norri	The law rate has be sage 2 sh	Completed by Physician/Me	Chromi lyng	hocytro	Leck	emio				24a. Was	psv	prior to co	ppsy findings available mpletion of cause of
5 =	iclan: The lav certificete has rector, page 2	S		0						1 ☐ Yes	2 No	death? 1 ☐ Yes	2□ No
ر <u>چ</u>	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			100	hor		h (Check only			
Sea	Phys rat dii	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		R/Outpatien 28b. Time of	30 DOX	# 🗆 '	Nursing Ho	ome 5 ☐ Resi	dence 6 0 how injury occi		(y)
	eath. or: After the funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mon	th, Day Year)	Injury	Wo	nk? ]Yes 2	□No		,,		
bert Bea	Atten r dea ctor	ifica	3 Suicide 6 Could no	ot be 28e. Place	of Injury - At hor	ne, farm, str	eet, factory, office			28f. Location (	Street and Nun	nber or Run	al Route Number,
عَ مِ	s afte	Certification;	4 Homicide	Build	ing, etc. (Specify)					City or To	wn, State)		
Robert	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur		(Check only 2 Medical E	Physician: To the xaminer: On the b	asis of examinati	rledge, death	occurred at the t	ime, date opinion, d	and place, eath occur	and due to the	cause(s) and r	nanner as s	stated. the cause(s)
Sur	thin 2- thin 2- the I	Medicai	one)  29b. Signature and title of certifier	and man	ner stated.		29c. Licen				29d. Date sign		
	- X - 0		Sold and the or certifier	100	0 0				815	-	,	0 0	
			30. Name and address of person w	to completed com	ea of death (les-	22a) /Tues			0 1 )		1, 3		
			Daniel Alexand					Road	. T.ec	nardto	m. Mar	vland	20650
	Sta	ite	31. Date filed (Month, Day, Year)		legistrar's Signati				,			, rund	
	Regist	rar	OCT 0 3 2006	Kene	K	and a							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2000

Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 27 2006 11:45PM ELINORE ANNE PEABODY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON 6202 WATERLOO DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y SEPT • 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral NEW JERSEY 1 ☐ M 2 K F Yrs. 103-12-9981 Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location show. r than "natural, or itema 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director **EASTON** MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6202 WATERLOO DRIVE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. INTEGRATED Elementary/Secondary (0-12) College (1-4or 5+) CONTAINER SERVICE 12 OFFICE MANAGER 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental F 7 is marked ot EDWARD L. LOCKE MARY E. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 Is
any injury or other trau ROYCE ALLEN PEABODY/HUSBAND 6202 WATERLOO DRIVE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 9/30/2006 OXFORD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA NOHO! Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Immediate Cause (Final disease or condition resulting in death) Physician Mulweria /Medical Due to (or as a consequence of): Examiner WVO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be execu Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 21 No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; After Hoapital or Attending 24 hours after death. 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 009024 onotel, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Dover Street Easton, Maryland 21601 Robert M. McDonald, M.D. 31. Date filed (Month 32. Segistrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryla	and / Depa	artment of H	ealth and I Death		en <b>2</b> e () () (	32536
1	Physici /Medic	an	Decedent's Name (First, Middle,     Steven		Phillips			2. Date of Death	Day 200	3. Time of Death
3	Examin	_	4a. Facility Name (If not institution, g Devlin Manor Nu			4b. City, Town, or Cumberla		h	4c. County of Allegan	
	Funeral Director				rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Birthplace (State or Foreign County)
	Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  MD Allega		City, Town or Lo	ocation Derland				10d. Inside City Limits 11€ Yes 2 □ No
	with the P or 28e-	Direct	10e. Street and Number 22 W. First Stree	+		10f. Zip Code	21502	10	g. Citizen of Wh	·
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mportant: If item 27 is marked other then "natural", or Itame 23s or 28s-f show my hiurry or other traumatic event, he Medical Event are must be notified at DDEs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed	12. Was Decedent Ever in Armed Forces?		Was Decedent of Hi If Yes, specify Cuba		specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc.
Maryland 21215-0036	within 72 hou iene. then "natura the wedical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupa a kind of work done o DO NOT use retired	turing most of wo	rking	6b. Kind of Busi	ness/industry
land 2	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, La Leonard J. Phi				Mary I	<sub>ne (First, Middle, M</sub> Miller		
	nd 2 sho aith and N 27 is ma ir trauma		19a. Informant's Name/Relationships	о (Турв, Print) brother	19b. Maili 221	ng Address (Street a Cottonwoo	and Number or Ri od Drive	ural Route Number, Oakda	City or Town, St e	PA 15071
Baltimore,	Pages 1 and neut of Hean ant: If item		20a. Method of Disposition  1 ☑Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemetery, cre	osition (Name of matory or other plac emorial Gard	dens	Date 2		ity or Town, State
Balti	permit. I Departm Importa eny Inju		21. Signature of Funeral Service L		. 2	<sup>2. Narr</sup> Scarpelli 108 Viro		ome, PA e: Cumberla	and, MD 2	1502
	Physician /Medical Examiner		23a Part. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the daily one cause on each line.  a	yngral	ter the mode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
760, 😽	ite be executed ysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	
α.	quires that in signed build be deta	ρ	Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause give	en in Part I.			oute to the cause of death?  3 Probably 4- Unknown
of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings available for to completion of cause of lath?  Yes 2 □ No
Vita	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	a∏ EB/Outpatio	ent 3 DOA Oth	or	ath <i>Check only on</i>		(Spaciful)
ion of	ling h. Aftar funei		27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yea		of 28c. Injur		28d. Describe ho		
Division	el or Attences after death	Certification;	3 Suicide 6 Could no 4 Homicide determin		At home, farm, s ecify)	treet, factory, office		28f. Location (St. City or Town		r or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	edical (		Physicien: To the best of my xaminer: On the basis of examiner stated.						
	To the I within 2 To the I complet	M	29b. Signature and title of certifier	lun MI		29c. Licens	e number		Oct 9	(Month, Day, Year)
	6		30. Name and address of person w	ho completed cause of death	(Item 23a) (Type	Aug L	- Vzie	/\n\).	21502	
	Sta Regist		31. Date filed (Month, Day, Year)	ho completed cause of death ・ たっ	ignature	parte				

Physician		For State Registrar  Decedent's Name (First, Middle, Last)	1	Cer	inicate of	Death	2. Date of De	Reg. No.	3. Time of Death
18.415 - m	n	John Michael Quade					Month Oct. 1	Day Yea	
/Medical		a. Facility Name (If not institution, give			4b. City, Town,	or Location of D		4c. County of De	
*	di.	39251 Danielle Way				icsville	U.S. T. S.	St.Mary	
Funeral Director	1	212-72-3344	7. Age (In yrs	(s. last birthday) Yrs.	If Under 1 Yea Months Day		Min. 8. Date of Bir (Month, Da February	9. Ed., Year) 26, 1956 Ma	Birthplace (State or Fore Country) aryland
ms 23a or 28a-f show Irrust be notified at	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Lim
in the part of the	ō	Maryland Saint Ma	arvs Me	chanics	sville				1 ☐ Yes 2 🛛
andi	lie	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
238 (	2	39251 Danielle Way			20659			USA	
r tems 23s or 28s-f signatures be notified	Line	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 XNo	U.S. 13. V	Mas Decedent of f Yes, specify Cu	Hispanic Origin ban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Black, W	merican Indian, hite, etc.
in in		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	1□Yes 2XN	o Specify:		Specify: W	hite
natural; or ite	erea	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decec	dent's Usual Occ	upation e during most of	working	16b. Kind of Busines	ss/industry
and Mantal Hygiene. Is marked other then "natural, or liems 23s or 28s-f show aumatic event, the Medical Examinar must be notified at To Re Commissed by Eunarial Director	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Sı	DO NOT use reti uperviso	e during most of red) T		State Go	overnment
d oth		17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Sumame)	
Mental Marked o	<u> </u>	Lewis Benjamin Qua					Lee Morga		7.0
h and 7 Is m rraum		19a. Informant's Name/Relationship (Ty Linda Marie Quade,						oer, City or Town, State ville, MD 20	
perimit. Fages 1 and 2 should be partment of Health and Men Important: If flam 27 is marke eny injury or other traumatic once.	1	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	1	Date	20c. Location - City	
y or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Tr	cemetery, cren inity Mer	natory`or other p norial Gai	dens 0c	tober 2006	Waldorf, Ma	ryland
ortan injur	-	21. Signature of Funeral Service Licens		22	. Name and Add	race of Eacility			
Depa Impo eny ii		Michael Neva	Hardine	Li	attingley. eonardtown	·Gardiner n, Marylan	Funeral Hom d 20650	e, P.A. 41590	Fermick Str
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the d	Do not ent	er the mode of d	ying, such as car	diac or respiratory a	arrest,	Approximate Interval Betwee
nysician	4	Immediate Cause (Final disease or condition	GLIOBL	4970~	ma 1	10-17f	anno	-	Onset and Deat
Medical xaminer		resulting in death)	Due to (or as a conse						
	-	Sequentially list conditions,	Due to (or as a conse	equence of):					
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
the burial-transit	X	resulting in death) Last	Due to (or as a conse	aquence of):					
physicien the buria	edical		d						
ing pi		IF FEMALE:	220 If you system of oran						
attending   for use es	Physician/M	in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnar Other (specify)	псу		23d. Date of a	Day Toa
by the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	death 3C	J Other (Specify)				
	Y	Part II. Other significant conditions co.	ntributing to death but not re	esulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death
ned b a deta							E	Yes 2 40 3	Probably 4 Unkn
on signed build be deta	Q						_ 10	/	
is been signed be should be detailed by Different by Diff	pieted b						24a. Wa:	s an 24b. Were	autopsy findings avai
ate has b	ompieted b						24a. Wa:	s an 24b. Were pror ormed? death	to completion of cause
ate has b	Completed	25. Was case referred to medical examiner?					24a. Wa:	s an 24b. Were prior death 2200 1 🗆 Y	to completion of cause 1?
his certificate has be director, page 2 s	To Be Completed	examiner? 1 Yes 3 No		☐ ER/Outpatier	II 3LI DUA	Other: 4 Nursi	24a. Wa: autr perf 1 □ Yes Death <i>Check only</i>	s an 24b. Were provious ormed? death of 2000 1 1 Y one)	to completion of cause i? ′es 2□ No
his certificate has be director, page 2 s	To Be Completed	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 2   28a. Date of Injury (Month, Day Year)		f 28c. In	Other: 4 Nursii jury at York?	24a. Was autoperfiners. Death Check only ng Home 5 Res	s an 24b. Were prior of death 2 2 2 No 1 Y	to completion of cause i? ′es 2□ No
ath.  r. After this certificate has be funeral director, page 2 s	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At	28b. Time of Injury	f 28c. In W	Other: 4 Nursii jury at łork? Yes 2 No	24a. Was autoperfile Yes  Death Check only ng Home 54 Res  28d. Describe	s an 24b. Were provided to the	to completion of cause 'es 2 □ No
ath the control of th	To Be Completed	examiner? 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. In W	Other: 4 Nursii jury at łork? Yes 2 No	24a. Was autoperfile Yes  Death Check only ng Home 54 Res  28d. Describe	s an 24b. Were provided in the composition of the c	res 2□ No
ath.  r. After this certificate has be funeral director, page 2 s	Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier Certifying Phy	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials: To the best of my kills.)	28b. Time of Injury home, farm, str	f 28c. In W 1 1 2eet, factory, office the occurred at the	Other: 4 Nursii	24a. Was a subset of the control of	s an 24b. Were provided in the	to completion of causes? 'es 2 □ No 'ipecify)  Rural Route Number, as stated.
ath.  r. After this certificate has be funeral director, page 2 s	ledical Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Special Control of the Control	28b. Time of Injury home, farm, str	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m	Other:  4 Nursii pury at fork?  Yes 2 No	24a. Was a subset of the control of	s an 24b. Were provided in the	to completion of causes?  'es 2 No  specify)  Rural Route Number,  as stated.  fue to the cause(s)
Funeral Director: After this certificate has being filled in by the funeral director, page 2 s	ledical Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Spectralician: To the best of my kinner: On the basis of examiner:	28b. Time of Injury home, farm, str	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m	Other: 4 Nursii	24a. Was a subset of the control of	s an ppsy ormed? 24b. Were prior death 1 Y one death 1 Y o	to completion of causes 'es 2 No 'ipecify)  Rural Route Number, as stated, due to the cause(s)
ath. r. After this certificate has b te funeral director, page 2 s	ledical Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, str cify)  nowledge, death	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m 29c. Lice	Other:  4 Nursii pury at fork?  Yes 2 No	24a. Was a subset of the control of	s an 24b. Were provided in the	to completion of causes 'es 2 No 'ipecify)  Rural Route Number, as stated, due to the cause(s)
ath.  After this certificate has been signed to functal director, page 2 should be considered.	ledical Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, str cify)  nowledge, death nation and/or in	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m 29c. Lice DL	Other: 4 Nursing Nursi	24a. Was autoperfile Yes  Death Check only ng Home 58 Res  28d. Describe  28f. Location City or To	s an ppsy ormed? 24b. Were pprovideath 1	to completion of causes  'es 2 No  specify)  Rural Route Number,  as stated.  fue to the cause(s)  onth, Day, Year)
within 24 hours elter death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s	Medical Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 29b. Signature and title of certifier  30. Nam d addre of person who could be determined	28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At building, etc. (Specials: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, str cify)  nowledge, death nation and/or in-	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m 29c. Lice DL	Other: 4 Nursing Nursi	24a. Was autoperfile Yes  Death Check only ng Home 58 Res  28d. Describe  28f. Location City or To	s an ppsy ormed? 24b. Were prior death 1 Y one death 1 Y o	to completion of causes  'es 2 No  specify)  Rural Route Number,  as stated.  fue to the cause(s)  onth, Day, Year)
ath.  After this certificate has be funeral director, page 2 s	a Medical Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At building, etc. (Specials: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, str cify)  nowledge, death nation and/or in-	f 28c. In W 1  reet, factory, office the occurred at the vestigation, in m 29c. Lice DL	Other: 4 Nursing Nursi	24a. Was autoperfile Yes  Death Check only ng Home 58 Res  28d. Describe  28f. Location City or To	s an ppsy ormed? 24b. Were pprovideath 1	to completion of causer  'es 2 No  specify)  Rural Route Number,  as stated.  due to the cause(s)  onth, Day, Year)

	•	For State of Maryland / Depa	rtment of Health and M	ental Hygier	71116	32538
Physici		Decedent's Name (First, Middle, Last)     EDWARD LEROY RAUM, JR.		2. Date of Death Month OCTOBER	9,2006	3. Time of Death 8:45 AM
/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	10.10.111
LAGIIII	Ģ	15550 POTOMAC RIVER DRIVE	COBB ISLAND		CHARLE	S
Funeral Director		5. Social Security Number 6. Sex (In yrs. last birthday) 2 1 3 − 4 0 − 7 1 4 2 7. Age (In yrs. last birthday) 7 (1 4 2 1 5 6 4 7)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JULY 30	9. Birthr Cour 1942 WA	
iled within 72 hours after death with the Maryland Hygiene. ther than "natural, or Iteme 23a or 28e-1 show out, the Modical Examinating and the retilised and the Modical Examination of the Modical Examination o	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
-UU30 Phours after death with the Marylan stural, or Iteme 23a or 28e-f ehow	Directo	MARYLAND CHARLES COBB 1	SLAND 10f. Zip Code	100	Citizen of What Cour	
a or 2			20625	log.	U.S.A.	iti y :
death me 23	Funeral	15550 POTOMAC RIVER DRIVE  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Americ	
after o		1 □ Never Married XXMarried 3 □ Widowed 4 □ Divorced  Amed Forces? 1 □ Yes 2 □ No 1 □ Yes, Give Yes, Give Year or Dates: 1960-1963  1 □ Never Married XXMarried 1 □ Never Married Yes 2 □ No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ours a	d by	3 Wildowed 4 Divorced Year or Dates: 1960-1963	Li res 2000 Specily.			ITE
72 hours "natural",	ete	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of worki O NOT use retired)	na l	. Kind of Business/In	•
withir than	ompieted	Elementary/Secondary (0-12)   College (1-4or 5+)	JCTION CONTROLL	•	EPT. OF	
	O	17. Father's Name (First, Middle, Last)		(First, Middle, Maio		
should be nd Mental marked o	To B	EDWARD LEROY RAUM, SR.	MARY	BLANCHE	FLYNN	Codel
2 2 2 2		, , , , ,	g Address (Street and Number or Rura  ) POTOMAC RIVER			ZUDZ
ite, No. 1 and of Health item 27 other tr		20a Method of Disposition 20b. Place of Dispos	ition (Name of	·	. Location - City or To	
A 0 0		1 K Hurial 2 L Cremation 3 L Hemoval from State 1	atory or other place) ETERAN'S CEM. 1	0-13-06	CHELTEN	HAM, MD
Dallimo permit. Page Department ( Important: If any injury or		21 Signature of Funeral Service Licensee MOO126 22.	Name and Address of Facility AYMOND FUNERAL			
		23a. Part1. Enter the disease, or complication. In at caused the death. Do not enter				
		shock, or heart failure. List only one cause on each line.	^	r respiratory arrest,		Approximate Interval Between Onset and Death
Physician		resulting in death)	HUCELL			
/Medical Examiner		Due to (or as a consequence of):				
2.	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
od ansit	Examiner	Cause Esta Underlying Cause (Disease or injury that initiated events  c				
be exec	Exa	resulting in death) Last Due to (or as a consequence of):				
	dicai	d				
D E Ora	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	anu
BOX eath cer attendir for use	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
the dy	ysi	1 Yes 2 No 9 Unknown				
ecords, P.O. law requires that the de as been signed by the 3 2 should be detached	by Pl	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
cords, wrequires t been signe should be				1 🗆 Yes	2 □ No 3 □ Prol	babiy 4 Onknown
2 8 8	piet			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
The The ate h	Completed			performed	? death?	
VICION: The corridicate rector, pag	Be (	25. Was case referred to medical examiner?		(Check only one)		
O 5 5 8	은	1 Tyes 2 Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Deal 28a. Date of Injury 28b. Time of		me Psidence 28d. De be how i		(y)
ding Ph ding Ph h. After th funeral	ion	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	200. Desd De now ii	njury occurred	
VISION OI VITA Attending Phyeicien: or death, ector: Atter this certific by the funeral director,	ertification;	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, stre			t and Number or Run	al Route Number,
tel or / s after al Dire	Certi	4   Homicide building, etc. (Specify)		City or Town, Si	tate)	
UIVISION  To the Hospitel or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or invariant manner stated.				
To the within To the complex c	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		12 May N	17421	2 10	011010	J
TH		30. Name and address of person who completed cause of death (Item 23a) (Type, I	s loplefo	· Mr	7 2-06	46
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 1 2 2006  32. Registrar's Signature	reele			

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER **Physician** Rhodes 2006 0023 Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Aug 16, 1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 234-20-9109 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County al Hygiene. other than "neturel", or Iteme 23s or 28s-1 ehow vent, the Madical Examiner must be notified at Cumberland Allegany MD 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 10546 Mt. Savage Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 NWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event <u>any injury</u> or other treumatic event Be Laura Priestley Pate Johnson Pate ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code), 10546 Mt. Savage Road Cumberland MD 21502 James Holbrook nephew 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 10/12/2006 Cresaptown MD 4 □ Donation 5 □ Other (Specify) 21. Signal of Funeral Service Licenses 22. Nam Scarbeins Füneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed physicien and Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy this certificate has been signed by the atterial director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown CORONARY ARTERY DISEASE 1 ☐ Yes 2 🛣 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 TYes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2006 D33280 3 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 625 KENT AVENUE SUNIL GUPTA, M.D. CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 32540 006 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 6:30 PM Ruth ct 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Lions Rehabilitation Center Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Apr 23, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 ☑ F Days Hours 204-03-8513 Yrs 88 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic svent. It e Medical Examination was been wifed at MD Allegany Cumberland Funeral Director 1x□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Wudleal Exempted 2008. 12 S. Lee Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married ☐Yes 2☐No 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ If Yes, Give Year or Dates: Specify: white 3X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) E.J. Fennell laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) E.N. Wenger Minnie B. Carmack Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Forrest Drive LaVale MD 21502 19a. Informant's Name/Relationship (Type, Print) daughter Roxanne Laird 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Memorial Park 10/7/2006 Hagerstown . MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lic 21. Signavir 22. Nam Scarbellis Pune Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNG **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an autopsy 1 Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation ours after death neral Director: A filled in by the fu death 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0054004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Lavale MD 21502 National Highway

State Registrar 31. Date filed (Month

Ruth, Minnie

1991 bgistrar's Signatur

Khanna

			1 _ State	aryland / Depa <i>Cei</i>	artment of He rtificate of D			2006	32541
			1. Decedent's Name (First, Middle, Last)		timodio or E		2. Date of Death		3. Time of Death
	Physici: /Medic		WILLIAM ALBERT ROWE, JR.				SEPTEMBI	,	06 7:10AM <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Dea	
			TALBOT HOSPICE HOUSE  5. Social Security Number 6. Sex 7. Aq	e (In yrs. last birthday)	EASTO		R Date of Righ		BOT thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Ag 1 M 2 ☐ F	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )	1919 M	RYLAND
	and W		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	jo	MD TALBOT		EASTON				1X Yes 2 ☐ No
	r 28e	Director	10e. Street and Number		10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	10	g. Citizen of What Co	ountry?
	1h with 23e o		46 LONDONDERRY DRIVE		2160	)1		USA	<u> </u>
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Evantment must be inclified at ODGE.	by Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Amed Forces?  1 Yes 2 Mily 1948, Give Year or Dates:	No	Was Decedent of His If Yes, specify Cubar 1□ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
2-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d	luring most of workir	ng 16	6b. Kind of Business	/Industry
121	within ene. than "	ldmc	Elementary/Secondary (0-12) College (1-4or 5	irle.	C.P.A.	)		ACCOUN	TTNG
<b>d</b> 2	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma		VIINO
ylar	Menta Menta arked atic ev	To B	WILLIAM A. ROWE				ET JAMES	·	
Maryland	d 2 sho h and 7 Is m treum		19a. Informant's Name/Relationship (Type, Print)  DOROTHY A. ROWE/WIFE		ng Address <i>(Street</i> a LONDONDERR			City or Town, State,  MD 21601	Zip Code)
٠ ف	Healt Healt tem 2		20a. Method of Disposition	20b. Place of Dispo		, D		Oc. Location - City or	Town, State
altimore,	Pages nent of int: If i		1		S CEMETER	· ! .	/2006	CHESTERTOW	N, MD
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	// I	2. Name and Addres FELLOWS, E	s of Facility  IELFENBEIN	N & NEWNA	AM FUNERAI	. НОМЕ РА
	Physician /Medical Examiner	ē	Sequentially list conditions b.	the death. Do not ent		g, such as cardiac o			Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examin	cause. Enter Underlying Cause (Uisease of injury that initiated events  c.	a consequence of):					
O. Box 6	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as in	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	11.5		23d. Date of de Month	olivery Day Year
rds, P.	quires than signed to det	by	Part II. Other significant conditions contributing to death t	out not resulting in the u	Inderlying cause give	en in Part I.			o the cause of death?
Vital Records,		Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 2 \( \sum \) No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Debe	26. Place of Death			
ō	ding Phys n. After this funeral dir	tlon: To	27. Manner of Death 1 Natural 5 Pending (Month, Da	ent 2 ER/Outpatie Iry 28b. Time of Injury	of 28c. Injury Work		me 5 □ Resider 28d. Describe hov	nce 6 XOther (Spe v injury occurred	ecity) HOSPICE
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of In	iury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	iural Route Number,
	n 24 hospitel or n 24 hours afte ne Funerel Dir	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medicel Exeminer: On the basis of and manner st	f examination and/or in					
}	To the within 2. To the I complet	Me	29b. Signature and title of certifier  Character MD		29c. License	number		d. Date signed (Mon	
	5.		30. Name and address of person who completed cause of			מיניטאי איזי י	21601		
	Sta Regist		JORGE H. ABREGO M.D. 598 31. Date tiled (Month, Day, Year) SEP 2 9 2006 32. Regist	rar's Signature	MIVE, EAS	JAON, PID A	21001		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No 2 U U 6

Day

Physician
/Medical
Examiner

RAMON ROJAS

4b. City, Town, or Location of Death

Year 7 2006 2230 September 4c. County of Death

ALBO1

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heelth and Mental Hygiene.

Int: If Item 27 ie marked other then "natural", or items 23a or 28a-f show ury or other traumatic event, Item Medical Examines must be notified at Director \$ Be 2

permit. Pag Department Important: I any injury o

Physician

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

of Vital

Division

/Medical Examiner

as the burial-trans

ettending for use as

certificete has t irector, pege 2 s

after death.

within 24 hours a
To the Funeral I
completely filled

To the

0-1

director,

illed in by the

Examiner

Physician/Medical

Completed by

Medical Certification: To Be

Baltimore, Maryland 21215-0036

A 50

4a. Facility Name (If not institution, give street and number) THE MEMORIAL

HOSPITAL 7. Age (In yrs. last birthday) 1**X** M 2□ F 77 Yrs.

EASTON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 28, 1929

2. Date of Death

9. Birthplace (State or Foreign

066-26-5985 Usual Residence of Decedent

5. Social Security Number

10a. State TALBOT 10c. City, Town or Location

PUERTO RICO

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 No

10e Street and Number

CORDOVA 10f. Zip Code

10g. Citizen of What Country?

29425 WHITETAIL DR. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status

21625 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

USA Race - American Indian, Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

nxxYes 2 □ No If Yes, Give Year or Dates:

PUERTO RICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 No

Specify: WHITE 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12

College (1-4or 5+)

MAINTENANCE SUPERVISOR

SHIPPING

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame) ELISA MARQUEZ

PEDRO ROJAS

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

CAROLYN J. ROJAS/WIFE

PO BOX 388 CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

HURLOCK, MD

20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

MD EASTERN SHORE VET. 9/13/2006 4 ☐ Donation 5 ☐ Other (Specify)

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

21. Signature of Funeral Service Licenses Dotnowski m. C.F.S.P. Joseph

tmmediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy

3 ☐ Ectopic pregnancy

23d. Date of delivery Month Day

9 Unknown

4 Pregnant at time of death

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 ☐ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

27. Manner of Death

2 Accident

29a, Certifier

5 Pending investigation

Hospital: 1 Despatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

License number 3988

29d. Date signed (Month, Day, Year)

9/4/06

completed cause of death (Item 23a) (Type, Print)

29466 PINTAIL DRIVE, EASTON, MD 21601 DAVID SMITH M.D., 31. Date filed (Month, Day, Year)

State Registrar

2006



DHMH 17 Rev 1/2001

		1	For State Registrar	State	of Maryland			of Health of Deat			giene leg. No 200	6	32543
			1. Decedent's Name (First, Middl	e, Last)						2. Date of Dea Month		ear	3. Time of Death
П	Physicia /Medic		ELEUT	ERIA	R	RUEDA	,			Sept	27, 20	06	12:09P
3	Examin		4a. Facility Name (If not institution	n, give street and no	umber)		,	own, or Location			4c. County of		
			Manor Care H			(and british day)		ethesd Year   If Und		8. Date of Birth	Mont		ce (State or Foreign
	Funeral		5. Social Security Number 578-76-7535	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs. I. 87	Yrs.		Days Hours	Min.	Apr. 18	Year) 3.1919	Country	quay
	Director	-	Usual Residence of Decedent								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	yland		10a. State 10b. County			y, Town or Lo						100	d. Inside City Limits
	e-1	cto	MD Mor	ntgomery	7	В	ethes	da					1 □Xes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip 0				10g. Citizen of Wh		y?
	s 23a	rai	7401 West			0 142.1	Mar Danida	20817	Orinina /San	of Vac as No	U.S.2		s Indian
	item item	une	<ul><li>11. Maritaf Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed F	cedent Ever in U. Forces? 22 No	5.	If Yes, specif	y Cuban, Mexic	can, Puerto i	cify Yes or No- Rican, etc.)	Black,	White, et	
39	irs aft	by	3 Widowed 4 □ Divorced	If Yos C	aive		1 ☐ Yes 2	<b>⊠</b> No Speci	ify:		Specify:	Whi	te
21215-0036	within 72 hours after deeth with the Maryland ene. Then "natural" or items 23e or 28e-f ahow 'na Medical Ezandiner must be colified at	ted	15. Deceder (Specify only highe	nt's Education	4)	16a. Dece	dent's Usual	Occupation done during m	iost of workii	na	16b. Kind of Busi	ness/Indu	stry
2	thin 7	Completed	Efementary/Secondary (0-12)	1	(1-4or 5+)	life.	Domes	retired)		•	Home	۵.	
2	ygien ygien her th	ပ်	7th	1 1			Domes		thor's Name	/First Middle	Maiden Sumame)		
Maryland	be fill H ad off	Be	17. Father's Name (First, Middle,					18. MO		,	na Cabre		
Ž	hould d Mer mark matic	ဥ	Juan Den:			19b. Mailie	na Address (	Street and Nun			r, City or Town, St		Code)
<u>8</u>	od 2 s Ith an 27 is t		Ruth Crisco		nter	176	25 Ma	cduff	Ave	Olney,	MD 208	332	10
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-1 ahow important: if item 27 is marked other than "natural; or items 23a or 28e-1 ahow purpor other traumatic event, the Medical Examination institution at 2006.	-	20a. Method of Disposition			Place of Dispo emetery, crei	sition (Name	e of her place)	0	ate	20c. Location - C	ity or Tow	n, State
Baltimore,	Page nt: if	li	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	etro			9/28	/06	Alexar	ndri	a, VA
aĦ	permit. Depertmitimportal Importal any inju	- 1	21. Signature of Funeral Service	Licensee	/ /	) 2	2. Name and	Address of Fa			Funeral		
<u>m</u>	80 5 5 8	-	- Escel	18 4 /	med								MD20850
П			23a. Part1. Enter the disease, shock, or heart failure. List	r complications that t only one cause or	t caused the deatl neach line.	h. Do not en	ter the mode	of dying, such	as cardiac o	or respiratory ar	rest,	1	Approximate Intervat Between Onset and Death
,	Physician		Immediate Cause (Final disease or condition resulting in death)	a	00	Jeon C	9	ANCE	(2				
	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	uence of):							
		Je.	Sequentially list conditions,	b. — Due t	o (or as a conseq	uence of):							
	s ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>									
á	te be executed ysicien end ie burial-transit	Exa	resulting in death) Last	c. Due t	o (or as a conseq	uence of):							
760,		cai		d									
89	death certifica e attending ph id for use as th	Med	IF FEMALE:										-
Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregna birth 2 Feta	I death 3	☐Ectopic pre☐ Other (spe				23d. Date Mont		y Day Year
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pre 9□Uni	gnant at time of d known	ieain si	_ Other (spe	эспу)					
<u>α</u>	requires thet the	표	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	underlying ca	use given in Pa	art I.	23e. Did to	obacco use contrib	oute to the	cause of death?
ds,	puires	d by								10	Yes 2⊠No 3	☐ Proba	bly 4 🗀 Unknown
of Vital Record	> 11 0	Completed								24a. Was	an 24b. W	ere autop	sy findings available ipletion of cause of
Re	0 5 5	E								perfo	rmed?   de	ath?	
ital	ician: Th certificete ector, pag	BeC	25. Was case referred to medic examiner?	ai				26. PI	lace of Deatl	h (Check only o	one)		
Ž	0 v T	인	1 ☐ Yes 2 ♥ No			ER/Outpatie					dence 6 Other		)
	en file	on:	27. Manner of Death 1 ☑Naturaf 5 ☐ Pend		te of Injury onth, Day Year)	28b. Time o	of 28	Bc. Injury at Work? 1 ☐ Yes 2		28a. Describe i	how injury occurre	3	
isic	Attending r death. sctor: After by the fune	icat	3 Suicide 6 Could		ice of Injury - At h	ome farm st				28f. Location (	Street and Number	r or Rural	Route Number,
Division	after Direction by	Certification:	4 - Homicide deter	mined 209. Fla	ifding, etc. (Specif	fy)		,		City or To	wn, State)		
	To the Hospitel or Attandi within 24 hours after death. "To the Funeral Director: A completely filled in by the to	calC	29a. Certifier 1 Certify	ing Physician: To t	the best of my kno	owledge, dea	th occurred a	at the time, date	and place,	and due to the	cause(s) and man	ner as sta	ated.
	the He	ed	one)	and m	anner stated.	A and/or in				actine time,			
	5 × 5 00	Σ	29b. Signature and title of certifi	er				. License numb			29d. Date signed		
	4			When	M	X		100	212		9-2	E -	7000
			30. Name and address of perso	·					0	#20			D 20050
	St	ate	Dr. Anushii 31. Date filed (Month, Day, Yea	avan Da		ature	TO We	calcal	untr	ur Ro	OCKVILLE	. M	U 20850
	Regist		SEP 2	9 2006	egistrar's Signa	B. Ag	grade 1						

		1- For State of Maryland / Department of Health an Certificate of Death		Reg. No.	711116	
Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Da Month	Day		3. Time of Death  1:47 P
/Medic	al -	Marilyn Stull  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of C	Octobe		2006 County of Dea	
Examin	er	39020 Sonnie Way Clements		S	t. Mary	r†s
Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Hrs. 8. Date of Bin Min. (Month, Da March 1	y, Year)		thplace (State or Foreign ountry) yland
Maryland I-f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland St. Mary's Clements				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
3a or 28a	Direc	10e. Street and Number 10f. Zip Code 39020 Sonnie Way 20624			izen of What C	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rigitified at once.	by Fur	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Word Worded  12. Was Decedent Ever in U.S. Armed Forces? 1 Secure Size 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 1 Secure Size 14. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 1 Secure Size 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 1 Secure Size 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic Origin If Yes, Specify Cuban, Mexican, Forces 16. Was Decedent of Hispanic O	? (Specify Yes or No Puerto Rican, etc.)	-	14. Race - Am Black, Whi Specify: W	
21215-0036 d within 72 hours all giene. In then "natural", or the Medical Exern.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Marketing Agent	f working		ind of Business Marketi	
Maryland 2 nd 2 should be filed than Mental Hygis 27 is marked other r traumatic event, it	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Middle nerine Jer	Maiden	Surname)	
Aary 2 shou 1 and N 1s mai	7	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number of Print</i> )				Zip Code)
Baltimore, Noemit. Pages 1 and Department of Health mortant: If Item 27 mportant: If Item 27 and Injury or other 1		Charlene Annette Quade/ Sister 38536 Ted Drive Ave	Date	20c. Lo	ocation - City o	
altin mit. P. partme cortani injury	1	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility	0-3-2006 Brinsfiel	Cha d Fu	rlotte neral F	Hall, MD. Iome PA.
Bal permi Depa impo		Kyle S. Simons M01206 22955 Hollywood				yland 20650
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.			. 0	Approximate Interval Between Onser and Death
/Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):				
58760, icate be executed physicien and s the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):  d				
.O. Box (in the death certify by the ettending ached for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		***************************************	23d. Date of de Month	elivery Day Year
Dr ta the Life	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.				to the cause of death?
Records, The law requires t the has been signer age 2 should be	Completed	COPD Hyper Tensin	24a. Was	an	24b. Were a	utopsy findings available completion of cause of
	e Con		1 ☐ Yes	2 No		
of Vital Physician: T this certificate ral director, pa	To Be	examiner?	f Death Check only		6 ☐Other (Sp	ecify)
		27. Manner of Death 1 26 Natural 5 ☐ Pending 1 27. Manner of Death (Month, Day Year) 1 28. Time of Injury Work?	28d. Describe	how inju	ry occurred	
ivision of the rest of the res	Certification:	Accident   S   Ferbing   S   Ferbing   S   Ferbing   S   Ferbing   S   S   S   S   S   S   S   S   S		Street ar wn, State	nd Number or F e)	Rural Route Number,
Division  To the Hospital or Attention within 24 hours after death To the Euneral Director: completely filled in by the	edicai Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.  Check only one)	place, and due to the occurred at the time	cause(s date an	and manner a d place, and du	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier 29c. License number			ate signed (Moi	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	85	10	11-2-	06
	0	Dr. William Boyd II 25365 Point Lookout Road, Leor	nardtown,	Mary	land 20	0650
Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 3 2006				
DHMH 17 Rev 1/2	001	ORIGINAL				28.

State of Maryland / Department of Health and Mental Hygiene 32545 006 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 2006 8:02 A M October **Physician** Cecelia Catherine Short /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) August 27, 1920 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 K F 86 Yrs. Maryland Director 215-40-4016 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r Itams 23a or 28a-f show 1 ☐ Yes 2 🕅 No Lexington Park **Funeral Director** St.Mary's Maryland 10g. Citizen of What Country? 10e Street and Number 6001 Spring Valley Court Apartment 1 USA 20653 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Pages 1 and 2 should be filed within 72 hours after upent of Health and Mental Hygiene. Int: If itam 27 is marked othar than "natural", or Itar 1 ☐Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: **Black** Completed by traumatic evant, the Medical Example 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Housekeeper 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Hobbs Jones ပ James Darby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: If itam 27 is any injury or other trau once. Lexington Park, MD 20653 P.O. Box 1383 Shirley Ann Short/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October<sub>6</sub>9, Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee 41590 Fenwick Street Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each CEREBROVASCULAR BRAIN Immediate Cause (Final disease or condition resulting in death) S M days Physician /Medical Due to (or as a consequence of): **Examiner** CCIDEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) the detached 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISORDER 3 Probably 4 □Unknown 1 Yes 2 DHO SCIZURE 24b. Were autopsy findings available prior to completion of cause of death? ACUT YOCARDIAL NEARCTION 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA 1 Tyes 2 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending 1 Natural 21 Accident 1 ☐ Yes 2 ☐ No after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Allendy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL ROAD PRINCE FREDERICK MD .110 INWAR MUNSHI. State Registrar

06-07095 Patrick Ian Stewart

### Please Type or Print in Black Indelible Ink

ricuse Type of Time in Black machine in			
State of Maryland / Department of Health and Mental Hygiene			
Certificate of Death	Reg. No.	2006	325

		l-For State Registrar			Certif	icate of	Death	7			Re	eg. No.	20	<u>U 6</u>	32	54t
Physicia	1/	1 Decedent's Name (First, Midd	le,Last)								. Date of Deat Month	Day	Year		<ol> <li>Time of D</li> <li>2030 h</li> </ol>	
edical Examin		Patrick 4a Facility Name (If not institution	Ian		tewart	4	o. City. To	own, or Lo	ocation of		Septembe		ounty of	Death	2000 111	
		44605 Old St. Andrew			.,		Califor					St.	Mary's	8		
Funeral		5. Social Security Number	. 6. Sex	7. A	ge (In yrs. last	birthday)	If Unde Months	r 1 Year Days	If Under		8. Date of Bir	th (MM/DI	D/YYYY)	Foreign		
Director		515-88-5919	1 X M 2	F	31	Yrs.	I WIGHTING	Layo	ricars	141111	05/26	/1975	5	Cou	<sup>ntry)</sup> Ala	bama
any	ŀ	Usual Residence of Decedent  10a. State 10b. County			10c. City, To	wn or Locatio	n								10d Inside	City Limits
<b>*</b>	_	Maryland St.	Mary's				Cali	forn	ia						1 Yes	2 X No
Maryland 28a-f show d at once.	윯	10e. Street and Number	rary b		1		10f. Zip				1	0g Citize	n of Wha	t Count	ry?	
with the Maryland ns 23a or 28a-f sho be notified at once.	히	44605 Old St.	Andrew'	s Ch	urch Ro	ad		2	0619				ed			
eath with the items 23a ust be not	Funeral Director	11. Marital Status	12. Wa		nt Ever in U.S.	13. Was					ofy Yes or No ican, etc.)	- 14	4. Race - White,		an Indian, B	lack,
er deat	ᆵ		orced If Yes, Gi		2 No	1	Ves 2	X No	snecify:			l Si	pecify:	Whi	+0	
hours afte 'natural", Examiner	칅	15. Decedent's Education (Spe	or Dates		ompleted) 16	Sa. Decedent	s Usual (	Occupatio	n (Give k				d of Bus			
7 , _	Completed	Elementary/Secondary (0-12)	Coll	ege (1-4 o		during mo		Ü		use retire	d)					
5-003( Tiled within Hygiene d other tha	팂	12				Aircra	ft M			o Nama /F	First, Middle, I			ent	Contr	<u>actor</u>
1215-0036 d be filed within 72 lental Hygiene larked other than '	Be C	17. Father's Name (First, Middle									sta Rei			7		
21215-0036 Muld be filed within 7 Mental Hygiene marked other than	0 0	George E. St		1)		19b. Mailing	Address	(Street			ral Route Nun				Zıp Code)	
MD  Id 2 sho  Ilth and  In 27 is  aumati		George E. St	ewart /	Fat							A 6684					
Fe, and Freal Freal Free Free Free Free Free Free Free Fre		20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Remo	val from S	I	ce of Disposi matory or oth			etery,	١	Date	20c. Lo	cation -	City or T	own, State	
altimore, rmit. Pages I ar partment of Hee pportant: If ite		4 Donation 5 Other S	pecify:			sfie <u>ld</u>	l-Ech	ols_	Cr.	9-26	-2006	Chai	1ot	te E	la11,	MD
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other tranmatic event, th		21. Signature: St. Funeral Service	Licenson		_						nsfiel					
Physician		23a. Part I. Enter the disease, or	r complications	that cause	M01422 ed the death. De	0 not enter th	e mode c	IOLLY of dying, s	<b>WOOD</b> uch as ca	. Road ardiacion r	d, Leon	nard1 est, shock	COWN	<u>, MI</u>	Approxima	ate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	Uono	ing as	sphyxia									4		Onset and eath
Examiner		or condition resulting in death)			nsequence of).											
- A	١,	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a cor	nsequence of):											
	Examiner	cause. Enter Underlying Cause	C.													
		events resulting in death) Last	d.	r as a cor	nsequence of).											_
E E	n/Medical	X UNPENDED	AMEN	DED _	item#23a,	27.28a-1	f.perl	Æ.g86	60.10	)/20/0	6 TT					
8760, rifficate be exe ng physician a	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in t	t	yes, outo	come of pregnar	ncy							Date of			Year
certification ce	sician	past 12 months?	1	Live birth Pregnant	at time of death	, - =	al death ner (Spec	3 _ cify)	Ecropic	pregnan	Су	l N	1onth	D	ay	Teal
Box e death o	Physi		nknown 9	Unknown								1				
P.O. Box 68 ss that the death certi gned by the attendin te detached for use a	by P	Part II. Other significant condi	tions contribu	iting to de	ath but not resu	ulting in the u	nderlying	cause gi	ven in Pa	art I.					he cause of ably 4	
IS, P.C. puires that an signed I	ted										24a. Was				opsy finding	
Corc law re has be	Completed	-					-				autor perfo	osy ormed?	p d	rior to co	ompletion of	
tal Rec rian: The certificate ector, page	ပ္ပ	06.14	T				<del> ,</del>	DE Dinos	of Dooth	(Check or		2 No	11_	<b>✓</b> Ye	s 2	No No
Vital   ysician: his certif director,	Be	25. Was case referred to medic examiner?	Hospital:	Inpa	atient 2 E	R/Outpatient			other <sub>4</sub>		Home 5	Residen	ce 6 🗸	Other:	Scene	
ding Phy	1: To	1 Yes 2 No 27. Manner of Death	28a	Date of I		8b. Time of Ir	njury 2	28c. Injury	at Work	? 2	28d. Describe	how injur	y occurre	ed		
ision Attendin er death rector: A by the fu	atior				(	unknown		1 Y	es 2 X	No	unknown					
Division of Vital Records, rate or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Cou	uld not be 286		Injury - At hom	ie, farm, stree	t, factory	, office bu	iilding, et	3	28f. Location ( or Town, \$	State) 44	605 C	old S	t. Andr	imber, City CEWS
Divi		4 Homicide		pecify)	home			No. a sleet			hurch Ro	l. Cal	<u>iforr</u>	ria,	MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Medical	(Check only	aminer; On the	basis of e	my knowledge xamination and											
To To	Mec	29b. Signature and title of dertif		nner state	ed		290	c License	number			29d. D	ate signe	ed (Mor	ith, Day, Yea	ur)
		1 Dolort	Leur)					O.C.N	Λ.E.			Sept	ember	20, 20	006	
	1	30 Name and address of perso					Ctra	D = 141	R.	D 0400	11					
	_		Assistant M		xaminer trar's Signatur	111 Penn	Street	, Baitim	iore, M	D 2120	71					
St Regist	ate rar	31. Date filed (Month, Day Year	16	VE .	N A	medical										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month ROBERT ALLEN SMITH 23 10:25 PM Sept 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis HealthCare -The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 215-20-2205 81 AUG 14, 1925 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □ Yes X No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8639 NORTH BEND CIRCLE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 SALESMAN AUTOMOBILE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN WALTER SMITH PANSY MILDRED STEFFENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES D. SMITH/WIFE 8639 NORTH BEND CIRCLE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 9/28/2006 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. etween d Death Immediate Cause (Final disease or condition resulting in death) C 6 Examiner Į.

Physician /Medical Examiner

burial-tran

the use as

detached the

pe

signed by

this

el or Attending P s after death. Il Director: Atter t d in by the funera After

the Hospitel within 24 hours a To the Funeral ( Physician/Medical

ģ

Completed

Be

2

Certification:

Medical

attending physician

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Department of Health a Importent: If item 27 is any Injury or other tree once.

**Funeral** 

Director

show

item 27 is marked other than "natural", or Itams 23a or 28a-1 show other treumstic event, the Modical Examinar must be notified at

2 should be filed within 72 hand Mental Hygiene.

with the Maryland

death

3altimore, Maryland 21215-0036

Robert Smith

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Enterococcus gosis	Interval Be Onset and Weak
Due to (or as a consequence of):	week
Tue works a consequence of):  Tarken Soni sm	ilean
Due to (or as a consequence of):	

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 2 🗆 No

9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

3 □Ectopic pregnancy

23d. Date of delivery

26. Place of Death (Check only one)

Year Month Day

4 Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No Manner of Death

5 Pending investigation

6 Could not be

Hospital:

1 Inpatient

2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Natural

2 Accident

4 | Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

1D Crowley 6101

31. Date filed (Month, Day, Year) 32. Registrar's Signature



DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiena 32548 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** SEPTEMBER 8 2006 GEORGE ELMER STEVENS, JR. 12:15PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE TALBOT EASTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Days Hours Min. Months 75 Yrs 220-28-2290 Director JAN 16, 1931 **MARYLAND** Usual Residence of Decedent Pages 1 end 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant If item 27 is marked other than "netural", or Items 23a or 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits nt of Health and Mental Hygiene.
If item 27 is marked other than "netural", or Items 23a or 28e-f show or other traumatic event, If a Medical Examination is 1 ☐ Yes 2 📆 No **Funeral Director** MD TALBOT TRAPPE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29336 HOWELL POINT RD 21673 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Be Completed by Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) RURAL MAIL CARRIER U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE ELMER STEVENS, SR. MARY ELISE THUME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE FAYE STEVENS/WIFE 29336 HOWELL POINT RD., TRAPPE, MD 21673 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) LANDING NECK CEMETERY 9/14/2006 TRAPPE, MD 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph M. Ostnouski C.F. SI 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician pinal malignancy 5 months /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Shknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 28 No 1 Tes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 ANatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funaral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pselle D52251 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Mertin Cour Suite ! MATTHEW FISCHER MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1 5 For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 27, 2006 6:35A **Physician** Joseph Louis Smothers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Brunswick 620 6th Avenue, Brunswick, MD | House 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEP 15 1937 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 2 M 2 □ F 220-34-1046 69 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow The Medical Exercitive must be notified at Brunswick 1 X Yes 2 □ No MD Frederick Director 10f. Zip Code 21716 10e. Street and Number 10g. Citizen of What Country? USA 620 6th Avenue "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) PEPCO - Dickerson, MD Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) Clara Jenive Beaner Joseph Albert Smothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 6th Avenue, Apt. 205, Brunswick, MD L. Deloris Smothers, Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dongtion 5 ☐ Other (Specify) Resthaven Memorial Gardens 10/2/2/Frederick, MD 21. Signatur of Fringing Spirita Library William John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER NONSMALL **Physician** CELL LUNG 22 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has burnector, page 2 s autopsy performed? 2 No 1 Yes 2 1 No 1 Yes Division of Vital al or Attending Physicien: after death. ersi Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 146 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely fitled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) OCT 0 2 2006

BINDU GEORGE

and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D0056314

29d. Date signed (Month, Day, Year)

SEPTEMBER 28, 2006

1 - For State Registrar 1. Decedent's Name (First, Middle, Last)

Certificate of Death

32550 3. Time of Death

	Director
Baitimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury of other treumatic event, the Medical Evantual treatment to contain
)	Physician /Medical Examiner

Г			1. Decedent's Nam	e (First, Middle, La	ast)					2. Date of D		٧	3. Time of Death	
	Physici		Ma	ria	Shel	.enkova	L			Sept	. 25	, 200 <sup>°</sup> 6°	12:50p	
	/Medic Examin		4a. Facility Name (I	If not institution, gi	ve street and number)			4b. City, Town	or Location of Dea			. County of Deat	th	
	LAGITIT		Holv	Cross H	ospital			Sil	ver Spri	nq	Montgomery			
	Funeral		5. Social Security N			(In yrs. last bin	hday)	av) If Under 1 Year   If Under 24 Hrs.   8. Date of Birt				rth 9. Birthplace (State or Foreign		
	Director		none		1□M <b>2</b> (□F	89	Yrs.	Months Day	s Hours Min	(Month, D			ussia	
ı	D		Usual Residence o							.,,,,,,				
	anylan ehow		10a. State	10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits	
	Ma-1-	ţo	MD	Montgo	mery	Ger	mar	ntown					1 ☐ Yes 2 🛣 No	
	h th	ie	10e. Street and Nu	mber				10f. Zip Code			10g. C	itizen of What Co	ountry?	
	h wit	Funeral Director	19 Cl.	imbing	Ivy Court	:		208	7 4			Russia		
	deet	ner	11. Marital Status		12. Was Decedent I	Ever in U.S.	13. W	as Decedent o	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or N	0-	14. Race - Ame		
5	or its	Ē	1 Never Marr	ried 2 Married	1 □ Yes 2 🔽 N	lo				to nican, etc.)		Black, Whit		
3	filed within 72 hours after deeth with the Maryland Hygione. ther then "natural", or items 23a or 28a-f ehow the the Medical Esand of must be notified at	þ	3 ☐ Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		,	□Yes 24∑ N	o Specity:			Specify: W	hite	
5	72 hg	Completed	(Sner	15. Decedent's E		16a.	Decede	ent's Usual Occ	upation	rkina	16b. h	(ind of Business/	/Industry	
-	Po	pie	Elementary/Seco		College (1-4or 5	+)			e during most of wo	'All Ig				
1	d wild will be a state of the s	5			5		Hon	nemake	r			Own Ho	me	
2	al Hy oth	Be	17. Father's Name	(First, Middle, Las	t)				18. Mother's Na	me (First, Middle	e, Maidei	n Sumame)		
9	Aente Aente rked	To E	Ivan	Shelenk	ov				Prask	covya S	hel	enkova		
	2 should be and Mental is marked c		19a. Informant's N						et and Number or R					
Ž	atth a		Elena K	ravchun	ovskaya/d	daughte	er	19 C	limbing	Ivy Co			ntown, Md	
Ď	f Hei f Hei item		20a. Method of Dis			20b. Place of	Dispos	ition (Name of atory or other p	iace)	Date	20c. L	ocation - City or	Town, State	
2	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mantal Hygleine. Importent: if Item 27 is marked other then "natural", or items 23s or 28s-1 ehow important: if Item 27 is marked other then "natural", or items 23s or 28s-1 ehow eny injury on other treumatic event, Ital Medical Examination must be notified at once.			☐ Cremation 3 ( 5 ☐ Other (Spec	Removal from State			reek C		3/06	W	ash.,D	.C.	
	a de la		21. Signature of F	/			22	Name and Ado	ress of Eacility		DAT	CEDILE	an n a	
2	Per Per Proposition		X	1.1. Dx	4 00				d° rtnali					
			23a Part 1 Enter t	the isease or cor	nplications that caused	the death. Do r	ont ente	241 Co	lumbia I	SIVd.Si	LVe	r Spri	ng, Md20910	
			shock, or hea	ant failure. List onl	y one cause on each lir	10.				o or rospiratory	arrogr,		Interval Between Onset and Death	
	Physician		Immediate Cause disease or condition resulting in death)	on	a	estive		art Fa	llure					
	/Medical Examiner		TOSKING III GOLIN	•		a consequence								
	ZAGIIIII	_	Sequentially list co	onditions,		al Fibr		lation						
	sit ad	ine	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying		a consequence								
	and tran	Examiner	that initiated events resulting in death)	s 🔛	·	cticuli		S						
Š	e ex sien s		rooding in doding		Due to (or as	a consequence	or):							
	eath certificate be executed attending physicien and for use as the burial-transit	lan/Medical		•	d									
5	ing p	Mec	IF FEMALE:											
5	th ce tendi	an/l	23b. Was deceden		23c. If yes, outcome 1☐Live birth	2 Fetal death	3 🗆	Ectopic pregnar	ecy			23d. Date of del	,	
	ed fo	sici	1 ☐ Yes 2	□No	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify)				MOHUI	Day Year	
	at the	Physic	9 Unknown											
ก	as the gned	by			contributing to death be		the un	derlying cause	given in Part I.				the cause of death?	
2	en si ould		Coron	ary art	ery disea	ase				1	Yes 2	!□No 3□Pr	robably 4 Unknown	
2	aw re	Completed	Hyper	tension						24a. Wa	s an	24b. Were at	utopsy findings available	
	The I	E								per	opsy formed?	death?	completion of cause of	
5	iffica tiffica for, p	a)	25. Was case refer	rred to medical			_		26 Place of De	1 ☐ Yes ath (Check only		1 103		
>	/sicil	To B	examiner? 1 ☐ Yes 2 <del>反</del>		Hospital:	nt 2 ER/Ou	toatient	3 DOA				6 □Other (Spe	city)	
5	ar this		27. Manner of Dear	<u> </u>	28a. Date of Inju	y 28b. 1	ime of	28c. In		28d. Describe			0.177	
5	th. Afte	ē	1 ⊶Natural 2 ☐ Accident	5 Pending investigate	(Month, Da)	/ Year) I	njury		ork? ∐Yes 2. □No					
2	dea ctor	fica	3 🗌 Suicide	6 Could not	d 280. Place of inju	ıry - At home, fa	rm, stre	et, factory, offic	8				ural Route Number,	
5	after Direction	Certification;	4 🗌 Homicide	40.01111110	building, etc	c. (Specify)				City or To	wn, Stat	Θ)		
	spite		29a. Certifier	1 → Certifying P	hysician: To the best	of my knowledge	, death	occurred at the	time, date and plac	e, and due to the	cause(s	s) and manner as	s stated.	
	To the Hospitel or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the a completely filled in by the tuneral director, page 2 should be detached.	Medicai	(Check only one)	2 ☐ Medical Exa	nminer: On the basis of and manner sta	examination an	d/or inve	estigation, in my	opinion, death occ	urred at the time	, date an	id place, and due	to the cause(s)	
	Nithir Co th	Me	29b. Signature and	title of certifier					nse number			ate signed (Mont		
			120	nama	harf			D6	0826		Se	pt.26,	2006	
					completed cause of d	eath (Item 23a)	Type P	Print)						
			Kshama						Rd Silve	er Spri	na -	Md 209	02	
_		1					_				J /			

State Registrar

31. Date filed (Month, Day, Year) SEP 2 9 2006

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 32551 1- State Amend #17819a Per Inf C862 12/01/06 Overtificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** tetanelli Rose 8:05 AM 2006 22, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 90 yrs. Birthplace (State or Foreign Country)
 TN 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09/11/1916 6. Sex **Funeral** 1 □ M 2 🕅 F Director 413-16-2103 Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD 1 ☐ Yes 2 X No Director Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Winfields Lane 21054 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐Mo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify: Completed by Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Secretary Hospital 17. Father's Name (First, Middle Last) and son permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Itam 27 is marked oth eny lipity or other traumatic event sons. 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie James <del>Butcherson</del> Sarah Elizabeth Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Stfanelli (Son) 411 Beach Trail Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 9/25/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home PA 0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ongestive neart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 - Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatore and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DOOG3270 -M.D dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 8601 Highway, Suite 211. Veterans Millerville, MD 21108 31. Date filed Mor Registrar's Signa Registrar

State of Maryland / Department of Health and Mental Hygiene 06 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 845 PM JUNITH TAYLOR 28 2006 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner LAUREZ REGIONAL INSPITAZ PANCE GENRGE LAURGE 7. Age (In yrs. last birthday)

The second of the second o 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 X F 212-72-3292 Director 1956 Maryland Usual Residence of Decedent 10c. City, Town or Location Hygiene. other than "natural", or leame 23a or 28a-f ehow vent, the Medical Examinar must be notified at 10a Stale 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 3927 Blackburn Lane, Apt. 23 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours atter 1 X Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cable Support Technician Telephone Company permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 is marked other any njury or other traumatic event, poses. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvin Earl Taylor Thelma Bertha Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Bertha Taylor/Mother 21895 Pegg Road, Apt. 317, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) October 4, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Charles MemorialGardens 2006 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onsel and Death Immediate Cause (Final SEPTIC **Physician** SHO CK disease or condition resulting in death) 6 KOVRS /Medical Due to (or as a consequence of) Examiner PNEUMONOA 48 HEVILL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner anding physician and use as the burial-transit The law requires that the death certiticate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign. To Be Completed by CHROMIC ALCOUNTISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CELLVUTIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1X Yes 1 ☐ Yes 2 No 2<sup>™</sup> No of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one 1 Yes 2 No Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ell D 36974 04/28/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNDO - MYANISM 10724 UTTLE PATIONENT PALKWAY Cozumpia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 2006 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		ŕ	1 = For S1 Registrar	ate of Maryland	Cer	rtment of H	eaith and M Death	nentai Hygi Re	ene 2006	32553
	Physicia		1. Decedent's Name (First, Middle, Last)  ELMER MAILAND	THOMPSON				2. Date of Death OCTOBER	R 8,2006	3. Time of Death 7:30 AIM
10	* /Medic Examin		4a. Fecility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of Death	l	4c. County of Dea	th
			5520 RAPHEL DRIV	E		POMFRET			CHARI	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
4-	Director		023-20-1040   Usual Residence of Decedent	79	115.			MAR.14	1927 MAS	SSACHUSETTS
	/land		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	Mar. B-f el	tor	MARYLAND CHARL	ES P	OMFRE	ET				1 ☐ Yes 2X No
	ours after death with the Maryland ral', or Items 23e or 28a-f ehow Evarietrer must be molfilled at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath w		5520 RAPHEL DRIV		1		1675		U.S.A	
		Funerai	, , , , , , , , , , , , , , , , , , ,	Vas Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	hours after tural, or Ite	by F	1 Never Married 2 Married 1 3 Widowed 4 Divorced	XIYes 2 □ No IYes, Give Year or Dates: WWII	1	☐Yes XXNo	Specify:		Specify:	WHITE
ğ	72 hours 'natural', dicul Exz	ted	15. Decedent's Education		16a. Deced	ent's Usual Occupa	ition	ing	16b. Kind of Business	/Industry
2	I within 72 ho iene. r then *natur the Medical	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retired;	)	1	JNITED ST	PATES
2	filed w Hygier other th		12		CAPT	TAIN	18. Mother's Nam	10	MARINE CO	ORP.
and	o d a b	Be	17. Father's Name (First, Middle, Last)							
Maryland 21215-003	should not marke umatic	2	CHARLES THOMPS  19a. Informant's Name/Relationship (Type, I		19b. Mailin	g Address (Street a	RENETTE		City or Town, State,	Zip Code)
<u>8</u>	d2 ha 7 le tra		JEWELL S. THOMPS						MARYLANI	
Je,	- 7 6 6		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of atory or other place			20c. Location - City or	
Baltimore,			1 ☐ Burial 2X Cremation 3 ☐ Remo	vai from State	•			11-06	ALEXANDRI	IA, VIRGINIA
<u>=</u>	permit. Pag Department Important: any injury o	Ì	21. Signature of Funeral Service Licensee	M004	79 22	Name and Addres	s of Facility			
<u> </u>	8959		Muhals	4		AIMOND A PLATA	FUNERAL MARYI	AND 206	CE, P.A.	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death.	Do not ente	or the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician	ì	Immediate Cause (Final disease or condition resulting in death)	LIVER	CAR	CINO	MA		*	EN MUNTH
	/Medical Examiner		resulting in douting	Due to (or as a conseque	nce of):				U	
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):					
	d ansit	Examiner	Cause (Disease or injury that initiated events c.							
o O	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
68760,	ate be hysici the bu	edical	d							
_	- CD 05		IF FEMALE:	f yes, outcome of pregnance					20 L D. H. 4 A	
Box	death certift e attending id for use as	Completed by Physician/M	in the past 12 months?	1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
o.	0 0	ysic		⊒□ Unknown		- Caron (Speedary)				101
<u>a</u> .	res that igned b	y P	Part II. Other significant conditions contribu		-		A 5		acco use contribute t	o the cause of death?
ğ	w require been sig should b	ed b	CHRONIC OBS+	Phititie F	Phlm	VNAY	DIJEAnt	1 □ Ye	s 2□No 3♂F	robably 4 Unknown
000	The law requires that the tite has been signed by th bage 2 should be detache	piet						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
ř		E O						perform	red? death?	s 2 No
Vital Records,	Physicien: The this certificate aldirector, pag	Be (	25. Was case referred to medical examiner?			T <sub>a</sub>		h (Check only one	9)	
	Physic this c	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ El			4   Nursing Ho		nce 6 Other (Spe	ecity)
u C	ding f h. After funer	tlon:	1 Natural 5 Pending	8a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	rat (? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of	I or Attendi after death. Director: A I in by the fu	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At hom	e, farm, stre		.00		reet and Number or R	lural Route Number,
2	al or A safter I Direct d in by	Certification:	4  Homicide determined	building, etc. (Specity)				City or Town	. State)	
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	(Check only 2 Medical Examiner:	n: To the best of my knowl On the basis of examinatio and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifie			29c. License	number	29	d. Date signed (Mon.	th, Day, Year)
	ن سپر د د		· / Da	M		174	4436	0	oct 10	2006
	arl		30. Name and address of person who compl	eted cause of death (Item 2	23a) (Type, 1	Print)	Mala	act n	nd 206	
	Sta		3 Date filed (Month, Day, Year)	32. Registrar's Signatu	18	losels?	UMICI	11, 11	ja Sto	
	Registr	ar	115112200	To be to the second						

Daniel L. Thompson 06-07199 **UNK UNK** 

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 32554 2006 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year September 24, 2006 Daniel Leigh Thompson Medical Examiner 0118 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ridgely Avenue and Kirkley Annapolis Anne Arundel 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** oreign Maryland Director 212-98-7772 Months Days Hours 25 Aug. 8,1981 1 X M 2 Country) Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No "natural", or items 23a or 28a-f show MD Anne Arundel Annapolis permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other reaumatic veent, the Medical Examiner must be notified at once 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 114 Melvin Avenue 21401 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces 1 XNever Married 2 Married White, etc. 2XX No Yes White Widowed Divorced Yes, Give Year Yes 2 X No specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Thompson Enterprises 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Thompson Fritz Marilyn Berry Gary Ann Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 236 Westwood Road Annapolis, MD 21401 Gary F. Thompson/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Metro Crematory 1 Burial 2 XXCremation 3 Removal from State 10/2/2006 Baltimore, Maryland Donation 5 Other Specify: Hardesty Funeral Home, P.A. 12 Ridgely Avenue Annapolis, MD 23 Part I. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Examiner

**Physician** /Medical Examiner

Baltimore, MD 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the att funeral director, page 2 should be detached for Be Medical Certification: To thours after death uneral Director: A

Completed by

In mediate lause (Final disease	a Multiple Injuries					Death
r condition (sulting in death)  Sequential Vist conditions.	Due to (or as a consequence b.	of):				
Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Unecase or injury that initiated events resulting in death). Last	Due to (or as a consequence c.  Due to (or as a consequence					
UNPENDED	d AMENDED					
IF FEMALE:  (3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at time of c	2 Fetal death		nancy	23d. Date of delivery Month D	ay Year
Part II. Other significant conditio	ns contributing to death but not	resulting in the underlying	ng cause given in Part I.		cco use contribute to the 2 No 3 Proba	
			· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of S
25. Was case referred to medical			26. Place of Death (Chec	k only one)		
examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Othera Nurs	ing Home 5 Re	sidence 6 🗸 Other:	Scene
27. Manner of Death  1 Natural 5 Pendir 2 Accident Investi		28b Time of Injury 0115 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Driver auto fixe	injury occurred ed object collision	1
3 Suicide 6 Could determ	not be 28e Place of Injury - At		y, office building, etc.	or Town, State	et and Number or Run e) e and Kirkley, Ar	
Torrown oray	rsician: To the best of my knowle	-			·	ed.

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 24, 2006

State Registrar

within 7

and manner stated

Assistant Medical Examiner

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

and title of certifi

Melissa Brassell, MD

31. Date filed (Month

		For State Registrar	State of	of Marylan		artment of He rtificate of D			ene g. No. 2 () (	)6	32555
Physic		Decedent's Name (First, Middle	,	rd Erne	st Woo	dward		2. Date of Death Month October		Year 06	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution,		_		4b. City, Town, or l			4c. County of	f Death	
Funeral		Washington Cour  5. Social Security Number	nty Hospi 6.Sex	7. Age (In yrs.	last birthday)	Hagers If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ngton place (State or Foreign intry)
Funeral Director		231-26-5951	<b>№</b> М 2 Б	79	Yrs.	Months Days	Hours Min.	(Month, Day, May 17,			York
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Many I ehe	tor	Maryland Wash	ington			Hagersto	own				1 ☐ Yes 2 <b>X</b> No
or 28	Direc	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	hat Cou	intry?
e 23a	Funeral Director	20405 Kings Cre		cedent Ever in U	S 13.1	21742		pecify Yes or No-	U.S		ican Indian.
DESILITIOTE, MISTY ISLICE LEGIONO.  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28s-f show spilling or other traumatic event, the Madical Examitrat rivial by mudified at since.	by Fun	11. Marital Status  1 □ Never Married 2 🕱 Marri 3 □ Widowed 4 □ Divorced	Armed F	orces? 2 □ No ive		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes <b>¾</b> ☐ No	Specify:	Rican, etc.)		, White	
2 hou		15. Decedent	s Education		16a. Dece	dent's Usual Occupati kind of work done do	tion	kina 1	6b. Kind of Bus		
of thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use retired)	ing most or wor	ning	<i>m</i> = 7 = = 1	<b>-</b>	
filed w Hygier other ti		12 17. Father's Name (First, Middle, I	ast)		S	upervisor	18. Mother's Nan	ne (First, Middle, M	Telepl faiden Sumame		co.
lid be lental rked o	To Be	Norris F. Wood					Esth	er Spaulo	ling		
2 shou and N ie mai		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street a				State, Zi	ip Code)
t and tealth am 27 ther tr		Charlotte W. Woo	odward	(Wife)		5 Kings Ci	and the same of th		Stown, I		
ages of of the strict of the s		1 Burial 2 Cremation		JIAIO		osition (Name of matory or other place rg Cremato	10000	ber 11,		700	
artme vartme oorten injury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		SIL		2. Name and Address	2 20		smutns. vis Fu		, Maryland 1 Home
Dermi Departiment	ے	Jeller Le	= DAU	is Mo	1414 1.	2525 Bradl	bury Ave	. Smithsk	ourg, Ma	aryl	and 21783
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	caused the deat each line. HCROSC			, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		fire ATI		IELMUNITI.	<				HOURS
	er	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	D	(or as a conseq		7 C 9 10/11/1					110023
nd transit	Examin	that initiated events	с.								
icete be executed physicien and sthe burial-transit	dical Ex	resulting in death) Last	d	or as a conseq	quence of):						
Certifice certifice nding pt use as th		IF FEMALE:	220 Hyps or	utcome of pregna	2004						
is, r.C. box of the first that the death certification by the ettending be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	birth 2 Peta nant at time of c	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date Mon		zery Day Year
requires that seen signed be detailed	۵	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause give	n in Part I.			/	the cause of death?
e law	Completed				**			24a. Was ar autopsy perform 1 Yes 2	ned2 p	rior to co	topsy findings available completion of cause of
	BeC	25. Was case referred to medical examiner?						th (Check only one			
OI VIIA Physicien: this certific ral director,	၉	1 Yes 2 No			ER/Outpatier		4   Nursing n	ome 5 Reside			rfy)
T ga all	tion	27. Momer of Death  1 Natural 5 ☐ Pendin 2 ☐ Accident investig		nth, Day Year)	28b. Time o Injury	Work	at ? ′es 2 □ No	28d. Describe no	w injury occurre	ou.	
To the Hospital or Attending within 24 hours affer death. To the Funeral Director: Affei completely filled in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place	e of Injury - At h ding, etc. (Speci	ome, farm, sti ly)	reet, factory, office		28f. Location (Str City or Town	reet and Numbe , State)	or or Ru	ral Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and mar ite and place, a	nner as nd due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certified	. /	phys	ilcin	29c. License	number	29	d. Date signed	(Month	, Day, Year)
. 10		30. Name and address of person	who dompleted car	use of death (Iter		Print)	6783	0	ctubes	91	2006
17		De Gentruri	3 11	110 1	Tedic	al cam	pus 1	Ed. Ho	y. Mid	21	1740
St Regist	ate rar	31. Date filed (Month, Day, Year)	2 2006	Registrar's Sign	ature of	foods	•		/		

		1	_ State	State of Maryland		artment of H			giene Reg. No2006	32556
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	ysicia	ın	VIRGIE L. WYE	R				october	R <sup>D</sup> 04,2006	1525 M
	Medic		4a. Facility Name (If not institution, give str MEMORIAL CAMPUS – W			4b. City, Town, or CUMBERI		ath	4c. County of Dea ALLEGAN	
Fun	eral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birth	Year) 9. Bir	thplace (State or Foreign
Dire			220-58-0421 1 I	<sup>4 2⊠F</sup> 98	Yrs.	Months Days	Hours Mi	in. Nov. 7,	1907 Rito	hie Co., WV
P.	-C-4	F	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	eation				10d, Inside City Limits
aryla •hov	E D	٦								1 ☐ Yes 2X No
he M	all a	Director	WV Mineral  10e. Street and Number		Keys	10f. Zip Code			10g. Citizen of What Co	ountry?
with t	De l					267	126		USA	,
eath	8	era	Rt. 6, Box 6692	2. Was Decedent Ever in U.S	S. 13.1			(Specify Yes or No- erto Rican, etc.)		
fter d	i i	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No				erto Rican, etc.)	10.00	e, etc.
1215-0036 within 72 hours after death with the Manyland ane. than "natural; or items 23s or 28s-1 ehow	Exa	<u>۾</u>	3   Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: WI	HITE
5-0 72 hc	ical	Completed by	15. Decedent's Educa (Specify only highest grade	ition completed)	(Give	dent's Usual Occup	during most of v	working	16b. Kind of Business	/Industry
<b>2</b> 章 章	4	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	d)		0	II
tygier st	럞	S	17. Father's Name (First, Middle, Last)		Н	omemaker	18 Mother's N	Name (First, Middle,		Home
DE fi		Be						Elizabeth		
A Me	matic	၉	Corliss Sutton  19a. Informant's Name/Relationship (Type	Print)	19b Maili	ng Address (Street			or, City or Town, State,	Zip Code)
Ma d 2 s th an t7 ie i	trau		Wilda D. Kesner/Da		1	6, Box 6		eyser, WV	26726	
Heel	other	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - City or	Town, State
noi ages ant of t: If if	yor		1 XBurial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	•	matory or other place. ily Cemet		5. 7 006	Short Gap	WV
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: If Item 27 ie marked other than *natural; or items 23a or 28a-1 ehow	声	1	21. Signature of Funeral Service Liceusee			2. Name and Addre			neral Home	
B gg	è d	*	1 Brun to	Lill		85 S. Mai	in Stree			26
Physical Physicial Physician and Physician	lical	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.  d.	Due to (or as a consequence to (or a))).	uence of):	ojic S	trob	C.		Onset and Death 6 days
I Records, P.O. Box 68 The law requires thet the death certifice attending of	should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	c. tf yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of de Month	blivery Day Year
rds, P. quires thet	uld be deta	d by Ph	Part II. Other significant conditions cont Congestive her	nbuting to death but not resu	ulting in the u	undertying cause giv	ren in Part I. CWNU	23e. Did to	obacco use contribute Yes 2 No 3 F	to the cause of death?  Probably 4 □Unknown
Division of Vital Records, i or Attending Physician: The law requires tater death.  Director: After this certificate has been signs.	age 2 sho	Completed by	breast cance	2, Gorona Hyperter	ry a	rtery o	liseuse	24a. Was autop perfo 1 Tes	osy prior to death?	utopsy findings available comptetion of cause of
	clor, p	BeC	25. Was case referred to medical			*	26. Place of	Death (Check only o	one)	
f V Jysic Jis ce	dire	To	examiner? 1 ☐ Yes 2 ☐ No Ho	spital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Ot	ner: 4 Nursin	ng Home 5 ☐ Resid	dence 6 Other (Sp	ecify)
Division of Vital or Attending Physician: after death.	e funeral		27. Manner of Death 1 ☑ Hatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2∐No	28d. Describe I	how injury occurred	
Division all or Attents after deat	completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifi		reet, factory, office		28f. Location (S City or Tox	Street and Number or F wn, State)	Rural Route Number,
To the Hospital within 24 hours a	letely fills	Medical C	29a. Certifier 1 Gertifying Physic (Check orthy one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the ti nvestigation, in my	me, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To th Withir	сошь	Σ	29b. Signature and title of certifier	w.D		29c. Licen:	se number		29d. Date signed (Mor	nth, Day, Year)
			//semman,!			D	56207		OCTOBER 4	, 2006
	h		30. Name and address of person who cor	npteted cause of death (tten	n 23a) (Type					
-	3		Husam Seman		Me	morial C	ampus-W	MHS Cumb	erland, MD	21502
B	Sta egistr		31. Date filed (Month, Day, Year)  OCT 1 2 200	32. Registrar's Signa	tuler /	parts!				

32557

	1 - State Registrar			ificate of L	1		No.	3. Time of Death
nysician	1. Decedent's Name (First, Middle, La				İ	. Date of Death Month	Day Year	
Medical		er, Jr.				eptember	30, 2006	8:00 P M
xaminer	4a. Facility Name (If not institution, give				Location of Death		4c. County of Death St. Mary	
	22986 Wheeler Fa		s. last birthday)	Bushwo		. Date of Birth	0 Right	place (State or Foreign ntry)
neral : ector		XXM 2□F 56	Yrs.	Months Days	Hours Min	uly 4, 1	950 Wash	ntry) ington, DC
	Usual Residence of Decedent		City, Town or Loc	ation				10d. Inside City Limits
Trems 23s of 23s-1 silon  Trems of the control of t	Maryland St. Mar		<del>ishwood</del>	Palm Bay				1 Yes No
trational benefitied Funeral Director	10e. Street and Number 502. Nar	ragansett St.NE		10f. Zip Code		10g.	Citizen of What Cou	ntry?
al D	22986 Wheeler Fa	rm Lane			2907-1329		nited Stat	
l le	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	las Decedent of Hi Yes, specify Cuba	spanic Origin? (Specif n, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ameri Black, White	
वि	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes XIX No	Specify:		Specify: Wh	ite
Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Decede	ent's Usual Occup-	ation furing most of working )	16	b. Kind of Business/Ir	ndustry
dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		anical E			Dept. of	Justice
ပိ	12 17. Father's Name (First, Middle, Las	t)	Mech	allical	18. Mother's Name (i			ouseree
Be					Marguerit	e Daras		
2	19a. Informant's Name/Relationship		19b. Mailing	Address (Street	and Number or Rural F		ity or Town, State, Zi	ip Code)
	Lewis L. Wheeler				Farm Lane			
To	20a. Method of Disposition	20b	. Place of Dispos		Dat		c. Location - City or T	
_	1 ☑ Burial 2 ☐ Cremation 3 ☐ Value Donation 5 ☐ Other (Spec	ify)	VET.	Cheltenh	am 10/5/2	005 Cl	neltenham,	Maryland
any injury or	21. Signature of Funeral Service Lice  Kyle S. Simon	197	B P	Name and Address rinsfiel .0.Box 1	d-Echols F 28, Charlo	uneral l tte Hall	Home PA. L, Marylan	d 20622
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de	eath. Do not ente	er the mode of dyin	g, such as cardiac or i	respiratory arrest	,	Approximate Interval Between
an	Immediate Cause (Final disease or condition	Gastu		ancer				Onset and Death
al	resulting in death)	Due to (or as a cons		SCY (CC)				
ner	Conventially list conditions	b						
ner -	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (ursease or injury	Due to (or as a cons	equence of):					
Examiner	that initiated events	c						
		Due to (or as a cons	equence or):					
edlcai		d				_		
		23c. If yes, outcome of preg	gnancy				23d. Date of deli	verv
Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 □Live birth 2 □Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			Month	Day Year
y Physic	Part II. Other significant conditions	contributing to death but not i	resulting in the un	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
should be def						1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Completed						24a. Was an	24b. Were au	topsy findings available
, d						autopsy performs	⊈? death?	completion of cause of 2 \( \subseteq \text{No} \)
ပို			- 11 - 12 - 11 11		26. Place of Death	2 12 2 12	<b>5</b> 140   1 1 1 1 0 5	20.10
o Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth			ce 6 Other (Spec	sity) sons home
oral dire	27. Manner of Death	28a. Date of Injury	28b. Time of			3d. Describe how		
	Natural 5 Pending investigat	(Month, Day Year	) Injury		Yes 2 □No			
completely filled in by the funeral director, page Medical Certification; To Be Com	3 Suicide 6 Could not		at home, farm, stre	eet, factory, office	28	3f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
ert	4 Homicide	building, etc. (Spe	вспу)			C., C		
edical Certification:	29a. Certifier Certifying (Check only one)	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tivestigation, in my o	me, date and place, ar ppinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
Me Me	29b. Signature and title of certifier			29c. Licens	se number	1 290	d. Date signed (Month	
	, as	nuc	)	HC	105575	F	10-3	-00
	20 Name and adding at passage with	o completed cause of death (	Item 23a) (Type	Print)				
	30. Name and address of person wi		, ( . ) [,	,				
	Jennifer Schmi				eonardtown	, Maryl	and 20650	
State	Jennifer Schmi	Ldt, DO 40900  2. Registrar's Si	Merchant	s Lane I	eonardtown	n, Maryl	and 20650	
State Registrar	Jennifer Schmi	dt, DO 40900	Merchant	s Lane I	eonardtowr	n, Maryl	and 20650	

State of Maryland / Department of Health and Mental Hygien 2006 32558 For State Registra Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Grace Alberta Wilson October 3, 2006 6:33 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, July 31, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Yrs 216-30-9271 90 Maryland Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland 3/ Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location d other than "natural", or iteme 23s or 28s-f shovevent, it a Medical Exemples must be notified at 1 Yes 2 No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23423 Maypole Road USA 20650 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No ff Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: À Black. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Maid 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Hollv Edward Hopps ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38340 Sugarhole Road, Avenue, Maryland 20609 Kelvin Armstrong / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 0 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 4, 2006 22. Name and Address of Facility Mattingley-Cardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line timediate Cause (Final Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, fmmediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Year jo Month Day 4☐Pregnant at time of death 5 Other (specify) 2 should be detached signed by Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 No 2 No this certificate 1 ☐ Yes or Attending Physician: rector. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funaral Director: A the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 10-3-06 14285 completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers Dr. William D. Boyd, II 25365 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

32559

		•	For State Registrar		State of M	arylario				Death	III WIC		ag. No.	000	0 2 0 0 0
	Physicia		1. Decedent's Name			·						Date of Dea Month	Day	Year	3. Time of Death
	/Medic	ai -		NNE WAGN				45 675	T	or Location of		eptend		ounty of Death	
}	Examin	e i		_	street and number)				ast (		n Death			albot	
	Funanti		5. Social Security Nu	ımber 6. S		ge (In yrs. las	t birthday)	If Unde	r 1 Year	If Under	24 Hrs. 8	. Date of Birth	1	9 Rinth	place (State or Foreign
	Funeral Director		215-24-04	12	□M 2 <b>X</b> F	78	Yrs.	Months	Days	Hours	Min. J	AN 21,	192	8 MA	RYLAND
	and and		Usual Residence of 10a. State	10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
	Mary -I eho	Ş	MD	TAL	BOT		EAS	TON							1 XYes 2 No
	r 28a	Director	10e. Street and Num	ber				10f. Zi	Code				10g. Citize	on of What Cou	intry?
	23a c		201 WRI	GHTSON A	VE.				2160	1				USA	
36	a within 72 hours after deeth with the Maryland Jiene. r than "natural", or flems 23a or 28a-f ehow The Madical Examiner must be nutffield at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		12. Was Decedent Armed Forces  1 Yes 2  If Yes, Give Year or Dates:	?				Hispanic Ori an, Mexican Specity:	gin? (Specit i, Puerto Ric	fy Yes or No- can, etc.)		I. Race - Amer Black, White Specify: WE	
8	2 hou	ted		15. Decedent's Ed	ducation		16a. Deced	lent's Usu	al Occup	pation			16b. Kind	d of Business/li	ndustry
Maryland 21215-0036	within 7; ene. than "n	Completed	(Speci	ify only highest grandary (0-12)	College (1-4or	5+)	life. i	DO NOT	ork done ise retire	during mos d)	t of working				
21	filed wit Hygiene ther the	Son	12		0		H	OMEM	AKER	T				N HOME	
nd	ed la b	Be	17. Father's Name (									First, Middle,		umame)	
2	d 2 should be th and Mental ?7 is marked c traumatic ev	ဥ	19a. Informant's Na	PETRICK	Tuno Print)		19h Mailir	a Addres	c /Street			MISHE		Town, State, Z	in Code)
Na	12 s h ar 7 ts trau	i i	MARY ANN		rype, rminj	į		•				N, MD	·		<i>p</i> 0000,
	s 1 and 2 if Health item 27 l		20a. Method of Disp			20b. Plac	ce of Dispo	sition (Na	me of		Dat			ation - City or T	fown, State
Baltimore,	Peges ment of ant: if i			☐ Cremation 3 ☐ 5 ☐ Other (Specif	]Removal from State y)	)		-			9/26	/2006	EAS	TON, MA	ARYLAND
Balt	permit. Peges Depertment of b Important: if its any injury or of		21. Signature of Fu	neral Service Licer	merc	EROI	F	ELLO	NS.	ess of Facilit HELFEN RRISON	BEIN	& NEWN	IAM F	UNERAL 21601	HOME PA
			23a. Part1. Enter the	e disease, or com	plications that cause one cause on each	d the death.									Approximate Interval Between
	Physician		Immediate Cause ( disease or condition	Final	Due to (or as	-VICE	lar	- 1	= , \	onil	la-	tice	$\overline{}$		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	s a conseque	nce of):				_				
	Examiner		Esquantially list cor if any, leading to im	nditions,	Conc	e s t	رراح	2	av	01.00	myc	Gat.	NA.		
	ed sit	ulue	cause. Enter Unde Cause (Disease or	riving	Due to (or as	s a conseque	nce or).						1		
	xecut and al-trar	Examiner	that initiated events resulting in death) t		c Due to (or as	s a conseque	nce of):								
68760,	icate be executed physicien and s the burial-transit				đ										
89	·= 07 65	edical												1	
.O. Box	The law requires thet the death cert ate has been signed by the ettendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ∑ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3[	Ectopic   Other (s		:у			23	3d. Date of deli Month	very Day Year
<u>α</u>	thet the by detail		Part II. Other signif	icant conditions	contributing to death	but not result	ing in the u	nderlying	cause gr	ven in Part I		23e. Did to	bacco us	e contribute to	the cause of death?
ds	uires n sign	d by										101	/es 2□	No 3□Pro	obably 4 Junknown
Records,	tw requir s been si should	Completed										24a. Was		24b. Were au	topsy findings available
Be	The lav	mo										autop perfo 1 Yes	rmed?	death?	completion of cause of
Vital		0	25. Was case refer	red to medical						26. Place	of Death (	Check only o			
of V	\$ w 5	ToB	examiner?	No	Hospital:	ient 2□El	R/Outpatier	nt 3 🗆 🗆	OA Ot	her: 4 Nu	ursing Home	e 5 ☐ Resid	tence 6	☐Other (Spec	oify)
0			27. Manner of Deat	5 Pending	28a. Date of Inj (Month, D	ay Year) 2	8b. Time o Injury		28c. Inju Wo			ld. Describe h	now injury	occurred	
sio	ten deat tor: the	cat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b		***		M		Yes 2	No 28	of Location /	Street and	Number or Pu	ıral Route Number,
Division	후하는	Certification:	4 Homicide	determined	28e. Place of In building, e	atc. (Specify)	ie, rarm, st	reet, racto	гу, опісе		20	City or Tov		Transport of File	rai Houle Number,
	To the Hospitel or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the bes minar: On the basis and manners	of examination	ledge, deat on and/or in	h occurre vestigatio	d at the t	ime, date ar opinion, dea	nd place, an ath occurred	d due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	within To the compl	Me	29b. Signature and	title of certifier	^ ^			2	e. Licen	se number			29d. Date	signed (Monti	i, Day, Year)
			► Do		12 Af	) le	3 Me	0 1	00	5 Zi	10	5	enta	embe	~ 21,2006
-	()		30. Name and addr	ess of person who	completed cause of	death (Item 2	23a) (Type,	100					-1,		
	(4)				ELDS M.D.			HING	CON :	ST., I	EASTON	, MD 2	21601		
	Sta Regist		31. Date filed (Mon	SEP 2 5		rar's Signatu	ire ,		S.						

Registrar

Chagner. Many Anne

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar 32560 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day EDWARD HARRISON WALLACH, JR. Physician SEPT 29 2006 9:45P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY MONTGOMERY VILLAGE HEALTH CARE MONTGOMERY VILLAGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

APR 3 1929 Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**™**M 2□F 218-24-6533 Yrs. MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ehow. Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene.
ant: If them 27 is marked other than "naturel", or items 23a or 28a-f ehow ury or other treumatic event, if a Medical Exactinatinatics must be notified at 1 ☐ Yes 2 No BOYDS MD MONTGOMERY Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code DEOUDES ROAD 20841 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?/ 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 ☑Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ATTENDANT GAS STATION 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EDWARD HARRISON WALLACH BEULAH JORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHERRY CARTER / DAUGHTER 12424 DEOUDES RD., BOYDS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If eny injury or FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK CREMAT. 10/4/06 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LIVER METS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and id be detached for use as the burial-transit The law requires that the death certificate be executed **JAUNDICE** Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ASCITES Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No hes page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 1 Natural 2 Accident 5 ☐ Pending 1 Yes 2 No investigation within 24 hours after death To the Funeral Director: completely filled in by the t 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, OCTOBER 2, 2006 DA1165 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINU GANTI, 19529 DOCTORS DR., GERMANTOWN, MD MD 20874 32. Resistrar's Signature 31. Date filed (Month, 2 200\$ State Registrar

			For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of Hertificate of E	ealth and M Death		ien <b>2</b> 006	32561
	Physici /Medio		1. Decedent's Name (First, Middle, L ROSE ANN	ZAFFIRI				2. Date of Death OCTOBE		3. Time of Death 4:40p M
}	Examin		4a. Fecility Name (If not institution, garantee Union Hospita  5. Social Security Number 6.	1	ge (In yrs. last birthday)	4b. City, Town, or Elktor		R Date of Birth	4c. County of Death	n nplace (State or Foreign
	Funeral Director		202-18-1272 Usual Residence of Decedent	1 M 2 M F 7. A(	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 30	1926 Per	nsylvania  10d. Inside City Limits
	the Marylar 28e-f show	rector	MD Cecil  10e. Street and Number		Earlev:			10	ng. Citizen of What Co	1 ☐ Yes 2X No
	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28e-1 show treumatic event, if a Medicul Era: ther must be indifficultation.	Funeral Director	25 Holly St.  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces 1 □ Yes 21	No	21919 Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No-	J.S.A.  14. Race - Ame Black, White	
Maryland 21215-0036	n 72 hours at "natural", or edicul Erati	Completed by	3 XWidowed 4 ☐ Divorced  15. Decedent's to (Specify only highest g	If Yes, Give Year or Dates: Education rade completed)	16a. Dece (Give life.	1 Yes 2X No  dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work		Specify:	White
ind 212	be filed within tal Hygiene. d other than "	Be	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last Pasquale Perr		5+) S	ecretary	18. Mother's Name	e (First, Middle, N	Bottled Maiden Sumame)	Water
	1 and 2 should be i Health and Mental I tem 27 is marked o sther treumatic eve	ပ	19a. Informant's Name/Relationship Patricia Coyn	(Type, Print)	nter) 271	•		al Route Number,	City or Town, State, 2	
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2X Cremation 3 1 □ Donation 5 □ Other (Spec	ify)	Kent Cr	matory or other place emation	10/9	9/06	Smyrna,	
Ba	permi Depar Impor any ir		21. Signature of funeral Service Lice  23a Part. Enter the disease, or co- shock, or heart failure. List only	mplications that cause	M00510 $1$	18 West	neral E Cross S	St. Gal	ena. MD.	L. Schaec 21635 Approximate Interval Between
8760, %	Physician / Medical Examiner phisician and phisician and phisician and the pnital-Itausit	dicai Examiner	Immediate Causé (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Left Due to (or as	a consequence of):  a consequence of):  a consequence of):	rebral or	tey is f	foile	/re	Onset and Death
Box 6	death certifi e attending i d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
ords, P.O.	requires neen sign hould be	by	Part II. Other significant conditions  Hypertec	contributing to death I	out not resulting in the u		n in Part I.	1 □ Ye		obably 4 Unknown
of Vital Record	The lar ate has page 2	e Completed	25. Was case referred to medical				26. Place of Death	/	prior to death? No 1 □ Yes	topsy findings available completion of cause of
Division of Vi	Phys this al dii	Certification: To B	examiner?  1 Yes 2 No  27. Manger of Death  15 Natural 5 Pending investigati 3 Suicide 6 Could not	be Risco of In		f 28c. Injury Work M 1 \( \text{Y}	at ? /es 2 No	28d. Describe ho	eet and Number or Ru	
Div	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer			building, e	of my knowledge, deat	h occurred at the time			use(s) and manner as	
	To the Hy within 24 To the Fi complete	Medical	29b. Signature and title of certifier							n, Day, Year)
	12		30. Name and address of person wh	completed cause of	death (Item 23a) (Type,	Print)	+ EIK-	ton M	0 21921	(
	Sta Registr		31. Date filed (Month, Par Year)	2006 32. Reduct	rar's Signature	goarde				

			1 - For State Registrar	State of I	Marylan		artmen rtificat			ind M	ental Hygi	ene g. No.	106	32562
* <b>*</b>	Physic /Medi		1. Decedent's Name (First, Middle, La			ASKE	EW				2. Date of Death Month	Day	Year 2006	3. Time of Death
	Examir			es hos	PITA	4	4b. City,	EVE				4c. Cou	NINCE	
(W)-	Funeral Director		5. Social Security Number 6. S 243-72-5021	□M 25 F	Age (In yrs.	last birthday, Yrs.	Months	Days	If Urfder 2 Hours	Min.	8. Date of Birth (Month, Day, 02/27/			lace (State or Foreign try) Sor NC
	the Maryland 28e-f show	ector	10a. State 10b. County DC  10e. Street and Number			y, Town or L hingto					11	la Citizon	of What Coun	0d. Inside City Limits 1 1 Yes 2 □ No
	3a or	io i	1251 Mount Olive	t Rd. N.E	. apt	<b>.</b> # 2		002				USA	OI WIIIAI COUII	uy:
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mentel Hyglene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show my highly or other traumatic event, the Medical Event at must be inclined at DDC8.	ed by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E.	12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	is? ■No		Was Decedif Yes, special Yes	2 No	Specify:	jin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)	14. I	Race - Americ Black, White, on Black Black Business/Ind	etc. ick
21215	filed within 72 Hygiene. Ither then "ne Int, I've Medic	Completed	(Specify only highest gra	College (1-4)	or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	luring most	of workii	ng			
	should be filed with ind Mentel Hygiene. s marked other thei umatic avent, I'm	To Be Co	17. Father's Name (First, Middle, Last, Joe Askew			ı n	omema	ker			(First, Middle, M	Se laiden Sun	Lf Emp1	.oyed
Maryland	1 and 2 shou Health and M em 27 is mar ther traumat	1 5	19a. Informant's Name/Relationship ( Delores Askew-Gree		er	19b. Maili 4510	ing Address	S Lai	ind Number	r or Rura		City or To	wn, State, Zip larlbor	<sup>Code)</sup> 20772 o, Md.
Baltimore,	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Department 5 Other (Specification 5 Department)		te c	Place of Displacementery, crest	osition (Nar matory or o	ne of ther place	9)	D		oc. Locati	on - City or To	
Balti	permit. Pag Department important: t any injury o		21. Signature of Fue, ral Service Lieu	Zhe -	2)	²	2. Name an	d Addres	s of Facility	Fra	zier's I	uner	al Home	DC 20001
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reguing to immediate	a. SEPT	I CE as a conseq	MIF uence of):	4	e of dying	g, such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death I M CR TH
68760, <sup>T</sup>	The law requires that the death certificate be executed the bas been signed by the attending physicien and page 2 should be detached for use as the burial-transitions.	edical Examiner	iff any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. PS6  Due to (or	as a consequ	uence of):	JAS	T	nfe	~	N			i ri ontai
O. Box	that the death certifice led by the attending phe detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Fetal	Ideath 3[	⊒Ectopic pr ⊒ Other (sp					23d.	Date of delive Month	ny Day Year
rds, P	quires that n signed t uld be dett	by	Part II. Other significant conditions of	ontributing to death		ulting in the c			in in Part I.		23e. Did tob	4		e cause of death?
of Vital Records,	The law requi	Completed	CHRONIC RE	SIRA	TORY	F	41 LU	LE	=		24a. Was ar autopsy perform	ed?	prior to con death?	psy lindings available npletion of cause of
tal		0	25. Was case referred to medical	LEIO MC	. 200	A had	>C.		26 Place	of Death	1 ☐ Yes 2	No	1 🗌 Yes	2 No
<b>=</b>	× 5	To B	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2	ER/Outpatie	nt_3DC	Othe	r.		ne 5 ☐ Reside	100	Other (Specify	()
ion o	Jing Pl		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month,		28b. Time of Injury		8c. Injury Work		2	28d. Describe ho			
Division	tei or Attsnors after deatlai Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of	Injury - At ho etc. (Specify	ome, larm, st	reet, factory	, office		2	28f. Location (Str City or Town		umber or Rura	l Route Number,
	To the Hospitei or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examinat	wledge, deat tion and/or in	th occurred evestigation	at the tim , in my op	e, date and inion, death	d place, a h occurre	and due to the ca ed at the time, da	use(s) and te and pla	manner as st	ated. the cause(s)
)	Mith To 1	Σ	29b. Signature and title of certifier	Marin	M	1.5	290	Elicense Col	>511	48	5	d. Date sig	gned (Month, I	Day, Year)
9	3		30. Name and address of person to	completed cause of	death (Item	23a) (Type,	Print)	86	201	R	VER (	20	710	ANE
	Sta Registi	-	31. Date filed (Month, Pay, Year) 6 2	006 32. Aegi	strar's Signa	ture		þ		1			113	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 10:00 AM Genovaite Austra October 10, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint John's Nursing & Rehab Baltimore
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 K F Director 08/25/1921 <u> 213-30-7553</u> 85 Lithuania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 ehow the Medical Exactinar must be notified at 1 Yes 2 No Director Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 9620 Dundawan Road 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1□Yes 2XNo Specify: Specify: δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Is marked of permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Kazimieras Malakauskas Ona Gibavicius 19a Informant's Name/Relationahip (Type, Print)

JURATE JASKULSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jurate Jaskulaki - Daughter 9620 Dundawan Road Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer
Cemetery

22. Name and Address of Facility 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State 10/14/2006 Baltimore, Maryland 21 Signature of Funeral S. Ace Licenses David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lenter Caylo Vosseler desease **Physician** LIPAY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ DemenyiA 1 Yes 2 10 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes Division of Vital 1 Yes : After this certification, a Hospital or Attending Physicien: 25. Was case referred to predical Be 26. Place of Death Check only one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending efter death. 1 ☐ Yes 2 ☐ No М 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n by 4 Homicide filled 24 hours 1) Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/11/06 30. Name and aggress of berson who completed as of death (ment Lau) (Type 26.00 Scott Adam Rd #202 Cockeysuille Doas awrence 31. Date filed (Month, Day, Year) 82. Registrar's Signature OCT 1 6 2006 Registrar A TOTAL

DHMH 17 Rev 1/2001

07702			Ricage Ty	RAPS Arint i	p.Black ind	lelible-Inka	LIC		
iah T. Brown		Amend #108tal	te of Maryand A	Department	न जिल्लेक	ad Mental H	ygiene	0.0	06 0056
				Certificate	of Death				06 3256
Physici edical Exami		Decedent's Name (First, Middle, I Isaiah P. Brown	Last)				2. Date of Dea Month October 1		3. Time of Death 1808 hrs
		4a. Facility Name (if not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of	
		Sinai Hospital			Baltimore				
Funeral				(In yrs. last birthday			_	, 1	Birthplace (State or Foreign Country)
Director			XM 2 F	76	Yrs. Months Da	ays Hours Min	11/	12/1929	MD
iny		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or Lo	cation				10d Inside City Limits
h de si	Ļ	MD NSA	N/A	Ba1	timore City	7			1 X Yes 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Number	J		10f. Zip Code	-		10g. Citizen of Wha	t Country?
the Mannet		3800 W. Belvedere A	venue Apt. 21	L8		21215		USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent E Armed Forces?			Hispanic Origin? ( Sp an, Mexican, Puerto		0- 14. Race - White,	American Indian, Black,
er dea			1 Yes 2 2	No	Yes 2 X				
urs aft itural' amine	d by	15. Decedent's Education (Specify	or Dates:			pation (Give kind of v	work done	Specify: 16b. Kind of Bus	
5 72 ho m "na sal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or 5	+) durin	-	fe. DO NOT use reti	red)		,
5-0036 led within 7 Hygiene. other than	Completed	12th	<del>-unjkown</del>		factory wo				c Factory
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", cevent, the Medical Examiner	Be C	17. Father's Name (First, Middle, La Isaiah Harvey S.				18.Mother's Name	(First, Middle, Helen C	Maiden Surname) Brown	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Str	L reet and Number or F AVENUE_	Rural Route Nu	mber, City or Town.	State, Zip Code)
and 2 shou lealth and N tem 27 is n traumatic		Larry M. Brown	n / Son	553	1 Bosworth	Avenue n <del>Avwnue</del> ; Ba	altimore,	MD 21207	,
re, s l and f Heal If iten		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from Stat	20b. Place of Dis	position (Name of o	cemetery,	Date	20c. Location - 0	City or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec		Arbutus M	emorial Par	rk 10/2	20/2006	Baltimore	, MD
Balti permit Departm Importa injury o		21. Signature of Funeral Service Lic	censee	2	2. Name and Addre	ess of Facility	/lie Fune	ral Home. P	.A.
Physician		23a. Part I. Enter the disease, or co	ones that caused to	ne death. Do not ent	38 N. Gilmo	or Street; I	Baltimore	, MD 21217	t Approximate Interval
/Medical	-	failure. List only one cause on	each line. a. Cardiac Tampon		or the mode of dyna	g, sacri as saraiae e	respiratory an	rest, shock, of fleat	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec						2000
.~	L	Sequentially list conditions,	b. Due to Acute Let		ure				
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec c. Due to Acute My		on				
. g . ₹	Examin	events resulting in death) Last	Due to (or as a consec		antin Candinus	aulas Diasses			
executed an and al - transit	g	UNPENDED	Due to Hypertens	Sive Atheroscier	- Cardiovas	scular Disease			
60, ate be hysicia e buria	an/Medi	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of d	eliveny
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death 3	B Ectopic pregna	ancy	Month	Day Year
Sox leath c e atten for us	/sici	1 Yes 2 No 9 Unkno	Pregnant at ti	me of death 5	Other (Specify)			200	
O. E at the car the car the car the car tached	Phy	Part II. Other significant condition		but not resulting in th	ne underlying cause	e given in Part I	23e. Did to	obacco use contrib	ute to the cause of death?
res that	d by						1Ye	s 2 No 3	Probably 4 Unknown
ords	Completed						24a. Was autor		ere autopsy findings available or to completion of cause of
Reco The law icate has page 2 s	mo						perfo	rmed? de	ath? ✓ Yes 2 No
tal Rec cian: The certificate	Be C	25. Was case referred to medical examiner?			26 Pla	ce of Death (Check			
Physic rthis	ToE	1 ✓ Yes 2 No		t 2 🗸 ER/Outpati			-	Residence 6	Other:
n of iding Pl h. After funera		27. Manner of Death  1 V Natural 5 Pending	28a. Date of Injury (Month, Day,Ye	28b. Time		ijury at Work? Yes 2 No	28d. Describe	how injury occurred	1
ivision I or Attenc after death Director:	Certification:	2 Accident Investig	gation 28e Place of Inju	iry - At home, farm, s	3 5 5		28f Location (	Street and Number	or Rural Route Number, City
Div ital or ral Dir lled in	ertif	Suicide 6 Could n  4 Homicide	lot be	y / K Home, Idilli, 5	areet, lastery, office	bunding, etc.	or Town, S		of Rural Route Number, City
Hosp 24 hou Funer		20a Cortifior	sician: To the best of my	knowledge, death oc	curred at the time,	date and place, and	due to the caus	se(s) and manner a	s started.
To the within 2 To the Complet	edical		ner: On the basis of exam and manner stated.	ination and/or invest	igation, in my opinio	on, death occurred a	at the time, date	and place, and due	e to the cause(s)
- > - 0	ž	29b. Signature and fine of certifier	1/1/1	1		nse number			(Month, Day, Year)
		XXXX	-4/0		0.0	C.M.E.		October 14,	2006
2		30 Name and address of person when Susan Hogan MD. As	no completed clause of de ssistant Medical Ex		enn Street Pa	altimore, MD 21	201		
	tate	31. Date filed (Month, Day, Year)	32, Registrar's	19	All Street, Ba				
Renis		OGT 1 6 20	UD CENERAL	and a second					

Wayne Edward Byrd 1- For State

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 32565

		Registrar  1. Decedent's Nam	e (Firet Midd	le Lact)							10	Date of Dea	eg. No.		3. Time of D	eath
Physic Medical Exam												Month October 9	Day	Year	0228 hr	
		4a. Facility Name (				er)		4b. City, To	own, or L		Death			County of De		
E		5. Social Security I		6. Sex		Age (In yrs. las	st birthday)	If Unde		If Under	24Hrs	8. Date of Bi			Birthplace (State	or
Funera Directo		212-70-68	74	0.05	2F	.g= ( )10. ida	47 Y	Months			Min.		3/1958	For	eign Country) MD	
ž		Usual Residence of 10a. State	f Decedent 10b. County			10c, City T	own or Loc	ation							10d. Inside (	City Limits
Maryland 28a-f show any d at once,		MD	n/a	ì		. 55. Sity, 1		ore Cit	v						1 X Yes	·
larylar Sa-f s	Director	10e. Street and Nu				1		10f. Zip	-			1	l 0g. Citize	en of What C	ountry?	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygene. r-ked other than "natural", or items 23a or 28a-f she reat, the Medical Examiner must be notified at once	ä	1811 W. M	osher St	reet					2	21217				USA		
ath with tems 2.	Funeral	11. Marital Status 1 X Never Marri	ied 2 M		2, Was Decede Armed Force	s?		Vas Deceder Yes, specify				ofy Yes or No can, etc.)	D- 1	<ol> <li>Race - Am White, etc</li> </ol>	erican Indian, B	lack
fter dez F. or i	E.	3 Widowed		1	Yes, Give Year r Dates:	2 X No	1	Yes 2	X No	specify:			. 5	Specify B1	ack	
ours a atura	d by	15. Decedent's E	ducation (Spe	cify only	highest grade o			ent's Usual (					16b. Kı	nd of Busines	ss/Industry	- 1
5-0036 led within 72 hours after Hygiene. other than "natural". the Medical Examiner	Completed	Elementary/Sec			College (1-4 c	or 5+)			trici			-,		unkno	ריד.	
d with ygiene ther the	E	17. Father's Name		, Last)				CICC			Name (F	irst, Middle,	Maiden S		WII	
21215 21215 Auld be file Mental Hi marked o		Jacob Byr										Ange?	line E	Rocheste	r	
ID 21 should and Me 7 is ma	<u>ا</u>	19a. Informant's N Ruby Hami							•			ral Route Nu L <b>imore</b> ,			ate, Zip Code)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filted within? Department of Health and Mental Hygiene. The Prince 27 is him 27 is analyted other than mirry or other transmitte event, the Medica		20a Method of Dis	sposition				lace of Disp	osition (Nam				Date			or Town, State	
more		1 X Burial 2		-	Removal from	State		other place) Cemete	ry		10/1	7/2006	Ba1t	timore.	Maryland	
Baltimo permit Page Department of Important:	17	4 Donation 5 21. Signature of Fi	uneral Service		9			Name and	-					ne, P.A.		
<b>©</b> 50 5 5 5			ula		nes					or Str	eet:	Baltimy	ore. N	4D 2121	7	
Physicia: /Medica		23a, Part I. Enter t failure. List or		on each	line.		Do not ente	r the mode o	f dying, s	such as car	diac or r	espiratory ar	rest, shoo	ck, or heart	Approxima Between (	Onset and
Examine		Immediate Cause or condition result		_	ultiple Injurie le to (or as a cor		:				_				De	atti
		Sequentially list of		b												
	Examiner	if any, leading to it cause. Enter Und (Disease or injury	erlying Cause		e to (or as a cor	nsequence of)	:									
and and transit	Exar	events resulting in		Du	e to (or as a cor	nsequence of)	:									
exe an a	ian/Medical	UNPENDE	)		AMENDED											
68760, certificate be dding physici	/We	IF FEMALE: 23b, Was deceden	t pregnant in t		23c. If yes, outo				ء ٦	75-4:-				Date of deliv	•	Vons
	ciar	past 12 month	s?		1 Live birth 4 Pregnant	at time of dea		Fetal death Other (Spec	3	Ectopic	pregnano	су		Month	Day	Year
Box e death c the atten	Physic			known	9 Unknown											
, P.O. Box rees that the death c signed by the attent he delarged for use	Ş P	Part II. Other sign	iificant condi	tions co	ontributing to de	eath but not re	sulting in the	e underlying	cause gi	ven in Parl	t I.				to the cause of	
ords, I w requires is been sig	ted			<del></del>	_					<del></del>		24a. Was		OBTENDED.	autopsy finding	
COTC	1 =												ormed?	death		
tal Rection: The learning the l	<u>ි</u>   දි	25. Was case refe	rred to medic	al T				-	6 Place	of Death (0	heck on		2 No	1 🗸	Yes 2	No
Vital   hysician:	Be	examiner?	2 No	<u> </u>	spital: 1 Inpa	atient 2	ER/Outpatie			3thor: -		Home 5	Resider	nce 6 🗸 O	her Scene	
Division of Vital Records, Into Attending Physician: The law require rs after death. In Director: After this certificate has been signed in bursh of mean of should held in bursh of mean of should be a should be	Ě	27. Wathlet of Dea			28a. Date of I	njury y,Year)	28b. Time o	of Injury 2		y at Work?	Ip	8d. Describe edestrian				
Sion Attendi death. ctor:	atio	1 Natural 2 Accident		iding estigation			0214 hrs			es 2 🗸 I	NO I					
Divis  Divis  pital or At ours after d cral Direc	Certification:	3 Suicide		uld not be ermined		f Injury - At ho Parking Lot		reet, factory,	office bu	uilding, etc.	i	or Town,	State)		Rural Route Nu ad, Reisters	
Hospit St hour Funcra		4 Homicide 29a. Certifier (Check only	Certifying F	hysician	: To the best of			curred at the	time, dat	te and place						104411, 141
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Horarl Divine fraction: The first centificate has been signed by the attendance fractions have the financial diventor mans 2 should the desched from	Medical	one) 2	Medical Ex	aminer: C	on the basis of e	xamination an		gation, in my	opinion,	death occ						
<i>P</i>	<u>′</u>  ≚	29b. Signature an	d title of certif	ier	20			29c	License				1 .		Month, Day, Yea	r)
		Ca	1061	Ta	Wor		_		O.C.N	/I.E.			Octo	ober 9, 200	J6	
2		30 Name and add			mpleted cause of Medical Ex			Street, E	Baltimo	ore, MD	21201					
	State	24 2 4 51 144				trar's Signatyr		P								
	istra		DOTI	g 200	6 100	_	A P	a AF a								

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i> t	rtment of F	lealth and Death		gieną 00	6 32566
	Physici /Medic Examir	cal	4a. Facility Name (If not institution, given	TIN BALD  e street and number)		4b. City, Town, o	0		Day 11-46 S 4c. County of	
	Funeral Director		219-34-9673	TY GENERA)  Sex 7. Age (In yrs. 1a  7. The property of the pro	ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month. Day	r, Year)	9. Birthplace (State or Foreign Country) Maryland
(0)	72 hours after death with the Maryland natural; or items 23e or 28e-f show ileal Examinet must be notified at	Funeral Director	Usual Residence of Decedent  10a. State  MD  Prince  10e. Street and Number  11612 Laurel-Bow  11. Marital Status  12 Weer Married  2 Married	George's I  ie Road  12. Was Decedent Ever in U.S Armed Forces?  XXY'ss 2 \( \) No		10f. Zip Code  20fas Decedent of H	0708 lispanic Origin? In, Mexican, Pue	(Specify Yes or No-	10g. Citizen of Wh <u>USA</u> 14. Race Black,	10d. Inside City Limits 1 □ Yes 2 ▼ No nat Country?  - American Indian, White, etc.
nd 21215-0036	filed within Hygiene. sther then "	Be Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12th  17. Father's Name (First, Middle, Last	If Yes, Give Year or Dates: ducation ade completed)  College (1-4or 5+)	16a. Decede (Give k. life. De	ont's Usual Occupind of work done of NOT use retired	during most of w taker	orking ame (First, Middle,	16b. Kind of Bus	of Agricultur
nore, Maryland	1 and 2 should Health and Mer em 27 is marke ther treumatic	ToE	Rodner D. Baldw  19a. Informant's Name/Relationship ( Janet Baldwin/Si  20a. Method of Disposition  XX Burial 2 Cremation 3 C	Type, Print)  Ster  20b. Pla  Cei	11612 ace of Disposi metery, crema	Laurel- ition (Name of atory or other place	Bowie R	esa Lamme Rural Route Numbe Oad, Laur Date	r, City or Town, Si el, MD 20c. Location - C	20708 ity or Town, State
Baltimore	permit. Pages Depentment of I Important: If Its any injury or o		4 Donation 5 Other (Special Service Control of Funeral Service Control of F	nulla M0016	0 22.	Name and Addres	ss of Facility tt Aven	ue, Laure	Funeral  1, MD 2	Am, MD Home, P.A. 0707
	Physician Medical Examiner but and physician and the prinal-transit the prinal-transit	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	P	rent	fait nolu	nona	y em	botism	Interval Between Onset and Death  Aug S
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan  1 Live birth 2 Fetal of  4 Pregnant at time of dea	death 3 □E	Ectopic pregnancy Other (specify)			23d. Date Monti	
	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of Chromic Astr	T- 2 0	ting in the und			) ixv	es 2 🗆 No 3	ute to the cause of death?
	The ste h	Be Completed	25. Was case referred to medical examiner?	d'as etes	met	eli his	26. Place of D	24a. Was a autop: perfor 1 Yes	med? de 2000 1	ore autopsy findings available or to completion of cause of ath?  Yes 220 No
Division of \	tending Phys leath. tor: After this the funeral dir	Certification: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Injun Work M 1 🗆	4 🗆 1401 Sirily	28f. Location (S	ow injury occurred	
Ö	Hospite 4 hours Funare tely fille	dical Cert	29a. Certifying Ph	building, etc. (Specify)	large death on and/or inve	occurred at the fire stringstion, in my or	ne date and plac pinion, death occ	City or Town	supplied and conv	bet as stated. d due to the cause(s)
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.  D, FCCP		29c. License	number 845	2		Month, Day, Year)
	Sta Registr		30. Name and address of person who  31. Date filed (Month Day, Year)	completed cause of death (IJem 2	lum	rint) MA	- CHI	NGU	YEN, Y	ND, FCCP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 15, 2006 Lvle Κ. Baker 2:08 AM /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore Gilchrist Ctr. Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 5, **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min Feb. 421-14-7956 1925 Director 81 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shidical Examiner must be notified Director 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Sherwood Avenue 21239 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White etc ☐ Yes 2 f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No white Specify Completed by 3 ₩ Widowed 4 Divorced Year or Dates permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Payroll / Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph M. Kendia ٩ Gertrude H. Schroeder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin K. Baker son 1310 Sherwood Avenue; Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens: 10/18/06 Timonium, MD 21. Signature of Juner 1 pervic / Licen 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications t at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** worters /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown 1 □ Yes 2 □ No 3 ☐ Probably Be Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence Schother (Specify) NOS PCO 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760.

State Registrar 29b. Signa

30. Name

title of certifier

6

and address of person who completed cause of death (Item 23a) (Type, Print) W. TUNSON FOUN Uthruss, an 31. Date filed (Month, Day, Year)

2006

W)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2006

Ocroses

TD WSON

06-06794 Stanley Boswell Please Type or Print in Black Indelible Ink

Stanley Boswell		For State	ate of Maryla		artment of rtificate of		and N	Menta	l Hy		leg No	20	በፍ	325	568
Physician/	_	egistrar Decedent's Name (First, Midd	le,Last)					_	2	Date of Dea	ath		7	Time of Death	101
Medical Examine	r	Stanley	Bosv							Month Septembe				0707 hrs	
	4	<ul> <li>Facility Name (if not instituted Union Memorial Hosp</li> </ul>		imber)	2	b City, Tow Baltimo		cation of E	Death		4c	County of I	Death		
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	_	If Under 2		8. Date of Bi	rth(MM/D			olace (State or	
Director	:	155-68-7048	1 X M 2 F	41	Yrs	Months	Days	Hours	Min.	May 1.	5,19	65 [	Foreign Cour	N.J.	
8		Isual Residence of Decedent Oa State 10b, County		Inc. City	, Town or Locati	on								0d Inside City I	Limits
ow an	1	MD.			ltimore								- 1	1XX Yes 2	
te Maryland or 28a-f show any fied at ouce.	1	0e. Street and Number				10f. Zip Co	ode			1	10g. Citiz	en of What	Countr	y?	
the Maryland a or 28a-f sh tiffed at once Director		2543 Garret Av	ve.			212	18				U	.S.A.			
imore, MD 21215-0036  Pages I and 2 should be tiled within 72 hours after death with the Maryland ment of Health and Mental Hygiene fant: If item 27 is marked other than "matural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Marital Status     Never Married 2 M		cedent Ever in U		s Decedent of es, specify C				cify Yes or No Rican, etc.)	0-	14. Race White,		n Indian, Black	
er deat	3		1 Yes	<sup>2</sup> XX No	1	Yes 2 X	No s	necify:				Specify: B	laci	,	
urs afte	<u>-</u>	15. Decedent's Education (Spe	Lor Dates.		16a. Deceden	t's Usual Oc	cupation	(Give kın				ind of Busi			
5-0036 ed within 72 hour lygiene other than "natu the Medical Exan	<u> </u>	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during m	ost of workin	ig life DC	O NOT us	e retire	ed)					
036 vithin ene er tha Medic		12			Weldi	.ng		• • • • • •				nstru	cti	on	
21215-0036 add be filed within 7 Mental Hygiene marked other than c event, the Medica		7. Father's Name (First, Middle					18.1			First, Middle,					
2121 Jid be fi Mental J marked event,	<u> </u>	Archie Boswel  9a. Informant's Name/Relations			19b. Mailing	Address (	Street ar			ural Route Nu			State, 2	Zip Code)	
MD 2 short hand 27 is martis	1	Lillian S.Har	dy(Sister)	)	1626 H	lardy	Rd.,	Lune	nbu	rg,VA.					
re, l L and FHealt Fitem er tra	- 1 -	20a. Method of Disposition  1 X Burial 2 Crematio	n 3 Removal fr		Place of Dispos crematory or oth		of cemet	ery,		Date	20c. L	ocation - C	ity or T	own, State	
Pages nent of ant: I		4 Donation 5 Other S			swell Fa					14-06		nbrid			
Baltimore, MD 21215-003 permit Pages I and 2 should be filed withi Department of Health and Menial Hygiene Important: If item 27 is marked other th injury or other transmatic event, the Med	2	21 Signature of Funeral Service	Licensee		22. N	lame and Ad	dress of	Facility S	, Р.	Jones e,VA.2	& \$ p	n Fun	era	1 Home	
	-	Hullip Be	r complications that of	caused the deat	P.C	D.BOX	13,K	enbr	idg diac or	e, VA. Z	rest, sho	ck, or hear		Approximate In	nterval
Physician /Medical		failure List only one cause	e on each line.											Between Onse Death	et and
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequence		iai dis	CCISC								
Manager garden	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as :	a consequence	of):								-		
		cause. Enter Underlying Cause Disease or injury that initiated	с												
ted Insit	[   g	events resulting in death) Last		a consequence	of):										
ian and ial - tra	<u> </u>	X UNPENDED	dAMENDED	i+om#23	a PII 27	· MF	860	10/18	/06	TT					
Box 68760, e death certificate be the attending physici ed for use as the buri	<u> </u>	F FEMALE:	ho	outcome of pre		Miki iki gin						Date of d	,		
the death certificate the death certificate by the attending phyched for use as the Devicinary.	<u>a</u>  ∠	3b. Was decedent pregnant in t past 12 months?	LIVO.	birth nant at time of c	la ath	ital death her <i>(Specif</i> )		Ectopic p	oregnar	ncy		Month	Da	y Yea	ar
Box death he atte d for u	25	1 Yes 2 No 9 Ur	nknown 9 Unkr	nown	3 06	Her (Opcor)					1				1
· - > - 0		Part II. Other significant condi		to death but not	resulting in the i	underlying ca	ause give	en in Part	ı		_	_	_	ne cause of deal	
sign sign	2	Diabetes mellit	us							24a. Was				ppsy findings av	
tal Records rian: The law requirent certificate has been extor, page 2 should	Completed									auto		pri		mpletion of cau	
Rec The I	5									1 Yes	2 N		<b>√</b> Yes	2	No
ician:	a a	25. Was case referred to medic examiner?	Hospital:	Innationt 2 w	ER/Outpatient		100	Death (C		Home 5	Reside	nce 6	Other.		
of Viting Physic		1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury h, Day, Year)	28b Time of			at Work?		28d. Describe					
on con con con con con con con con con c			nding	h, Day,Year)			1 Yes	s 2 N	No I						
Division of Vital Rec pina or Atending Physician: The ours after death. filled in by the funeral director, page	E   23		estigation 28e Pla	ce of Injury - At	home, farm, stre	et, factory, o	ffice build	ding, etc.		28f. Location or Town,		nd <b>N</b> umber	or Rur	al Route Numbe	r, City
Dipital ours a ceral I filled	5	4 Homelda det	ermined (Specify					_							
Division of Vital    To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificompletely filled in by the funeral director.	ca	29a Certifier 1 Certifying I	Physician: To the be aminer:On the basis	est of my knowle of examination	dge, death occu and/or investiga	rred at the ti tion, in my o	me, date pinion, d	and place leath occu	e, and eurred at	due to the cat the time, date	use(s) and e and pla	d manner a ice, and du	is starte e to the	ed. cause(s)	
To the within To the country	8 -	29b. Signature and title of certif	and manner	stated	-		License r							th, Day, Year)	
m V.		(h. Se	4/10 1	2001.			O.C.M.	E.			Sep	tember	10, 20	006	
The Market		30 Name and address of person	n who completed cau	use of death (Ite	m 23a)						_				_
Jeby		Carol Allan, MD A	ssistant Medica		111 Penn	Street, Ba	altimor	e, MD 2	21201	l 					()
Stat	~~	31. Date filed (Month, Day, Year		Registrar's Signa	ture	E)									

DHMH 17 Rev 1/2001 OCME 2006

Amend Item State of Maryland O, 100/10006, dhealth and Mental Hygien 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6:00 1 M **Physician** BEUSEL 2006 /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Merces Medical N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2ŪF 53 Yrs. má. 8803 62 Director 214 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r then "naturel", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** BALTIMORE N/A MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5415 CEDELLA AVE. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify: BLACK Specify. ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE ADMINISTRATOR DAISSY FIELD 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental H 27 is marked ot freumatic ever Be Pages 1 end 2 should be f nent of Health and Mental I int: If item 27 le marked of NATHANIEL BEVERLY MARY DORETHA BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Cedella Ave.Baltimore, Md. 21206 WILBUR HARRIS (husband) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ö permit. Page Depertment of Important: If eny injury or once. MT.ZION CEM. OCT.13,2006 Donation 5 ☐ Other (Specify) BALTO, MD. Sunature of Funeral Service Licenses CALVIN B. SCRUGGS FUNERAL HOME 21213 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lachi acidosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physic for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by helperfeusion 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident s efter death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funerel [ 29a. Certifier **├** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. To the h within 24 To the F 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 ed cause of death (Item 23a) (Type, Print)

Registrar

and address of per

31. Date filed (Month, Day, Year)

OCT 1 6 2006

ST. Paul ST.

301

32. Registrar's Signature

			for State Registrar	olato of Marylana /	Department of Health and N Certificate of Death	Reg. N	2000	32570
			1. Decedent's Name (First, Middle, I	Last)		2. Date of Death	ay Year	3. Time of Death
	Physici /Medio		BERTINA	BROWN		CKTOBER	13 200	6 12:10 AM
1	Examir	er	4a. Facility Name (If not institution, g	rive street and number) 105P/TAL	4b. City, Town, or Location of Death  BALTIMORE		c. County of Death	ŕ
	Funeral Director		5. Social Security Number 219-22-0007	Sex 7. Age (In yrs. last)		8. Date of Brith (Month, Day, Yela	1928 19	place (State or Foreign, http)
	and and		Usual Residence of Decedent  10a, State 10b, County	10c. City, T	wn or Location		ı	10d. Inside City Limits
	Mary a-f ah	tor	4d Clarel	Enurdello Di	rvoklun			1 Yes 2 10
	death with the Maryland ms 23a or 28a-f show f must be notified at	Funeral Director	10e. Street and Number 222 50//	viar Ave	10f. Zb Code 21225	10g. C	Citizen of What Cou	ntry?
980(		d by Funer	11. Marital Status 1 ☐ Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Amed Forces?  1	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	within 72 hours after iene. than "natural", or its tra Medical Examica	Completed by	15. Decedent's (Specify only highest of Elementary) Secondary (0-12)	Education 16 grade completed)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work (II) ID NOT use refued)	ing 16b	Kind of Business/Ir	adustry Le
	il Hygid other vant, I	Be Co	17. Father's Name (First, Midgle, La	st) /	1001	e (First, Middle Maide	on Sumame)	
Maryland	should be ind Mental marked c	ToE	John Mora	chead		ie Dro	NUN	
	and 2 sh lealth and m 27 is m		19a Informant's Name/Relationship	Spikes 2	22 00 11 UIA / TVC	Baltine	ore Ho	12/225
Baltimore,	permit. Peges 1 Depirtment of H Important: if ita any njury or ott		20a. Method of Disposition  1 Dourial 2 Department 3 4 Donation 5 Dother (Special Control of Contro	city)	off, crematory or other place)  TON LIMITELY	17/06/La	Location - City or T	own, State
Ba	permit. Dep: rt Import any nj		21. Sharing of Funeral Service Lice	SCans.	22. Name and Address Facility (	Galfin	re Ma	21225
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	emplications that caused the death. Do by one cause on each line.  HYPOTENS	o not enter the prode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	a. Due to (or as a consequence				36 HRS.
		9	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. PNEUMON Due to (or as a consequence				48 HRS.
Ž	tificate be executed g physicien end as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SQUANCUS  Due to (or as a consequence		CANCE	3	13 DAYS
68760,	icate be physicie s the bur	edical		d				
Вох		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deal 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	ery Day Year
rds, P	w requires that been signed b should be dete	ed by PI	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
al Reco	: The law re cete has be page 2 sho	Completed				24a. Was an autopsy performed?	death?	opsy findings available impletion of cause of
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Other	h (Check only one)		
ō			1 165 2 40	1 ☑Inpatient 2 ☐ ER/C	Outpatient 3 DOA 4 Nursing Ho	me 5 Residence		fy)
on	ding Phys h. After this funeral di	tlon: To	27. Manner of Death  1 Natural 5 Pending	(Month, Day Year)	Time of 28c. Injury at Work?	28d. Describe how inj	ury occurred	
Division of Vital Records, P.O.	al or Attanding Physical deeth. I Director: After this din by the funeral din		/	be co- Blace of Initial Athens	Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj 28f. Location (Street a City or Town, Sta	and Number or Rura	al Route Number,
Division	a Hospital or Attanding Phy, 24 hours efter deeth. a Funeral Director; After this letely filled in by the funeral dietely filled in by the funeral d	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying 8	28e. Place of Injury · At home, building, etc. (Specify)  Physician: To the best of my knowledge.	Injury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street a	and Number or Rurate)	hatet
Division	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours effer deeth.  To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be deteched for use		1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Pending investigat 6 Could not determine	28e. Place of Injury - At home, building, etc. (Specify)  Physician: To the best of my knowledgaminer: On the basis of examination a	Injury Work?  1  Yes 2 No  farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rurate) s) and manner as s nd place, and due to	o the cause(s)  Day, Year)
Division	To the Hospital or Attanding Phy, within 24 hours effer deeth.  To the Funeral Director: Affer this completely filled in by the funeral di	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - At home, building, etc. (Specify)  Physician: To the best of my knowledgaminer: On the basis of examination and manner stated.  The state of Injury - At home, building, etc. (Specify)	Injury Mork?  1 Yes 2 No  farm, street, factory, office  ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur  29c. License number  RESOC	28f. Location (Street a City or Town, Sta	and Number or Rurate) s) and manner as s	o the cause(s)  Day, Year)
Division	To the Hospital or Attanding Phywithin 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral di	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - At home, building, etc. (Specify)  Physician: To the best of my knowledgaminer: On the basis of examination and manner stated.  The physician of the basis of examination and manner stated.	Injury Mork?  1   Yes 2   No farm, street, factory, office  ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur  29c. License number  RESOC	28f. Location (Street a City or Town, Sta  and due to the cause( red at the time, date as  29d. D	and Number or Rurate) s) and manner as signed place, and due to late signed (Month,	stated. o the cause(s)  Day, Year)
Division	To the Hospital or Attanding Physical Completely filled in by the funeral disconnected in the funeral disconnected	Medical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one) 29b. Signature and fittle of certifier 30. Name and address of person wh	28e. Place of Injury - At home, building, etc. (Specify)  Physician: To the best of my knowledgaminer: On the basis of examination a and manner stated.  The physician of the basis of examination a and manner stated.  The physician of the basis of examination a and manner stated.  The physician of the basis of examination a and manner stated.  The physician of the basis of examination a and manner stated.	Injury Mork?  1 Yes 2 No  farm, street, factory, office  ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur  29c. License number  RESOC	28f. Location (Street a City or Town, Sta  and due to the cause( red at the time, date as  29d. D	and Number or Rurate) s) and manner as signed place, and due to late signed (Month,	stated. o the cause(s)  Day, Year)

06-07632 Louise Boone Med

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

se boone		31a1 I - For State Registrar	e of Maryland / De	Certificate of		ia ivieritai i		g. No. 2006	3257
Physicia lical Exami	an/	1. Decedent's Name (First, Middle,	Boone				2. Date of Death Month October 10	n Dav Year	3. Time of Death 0830 hrs
		4a. Facility Name (if not institution,		4		r Location of Dea		4c. County of Death	
Funeral		Bon Secours Hospital  5. Social Security Number 6	Sex 7. Age (In )	yrs last birthday)	Baltimore If Under 1 Yea	ar If Under 24H	rs. 8. Date of Birt		hplace (State or
Director		2/2-96-7320 1 Usual Residence of Decedent	□M 2×F 26	Yrs.	Months Day	ys Hours M	in. January	4 1980 Foreig Cou	intry) placy land
15-0036  Hed within 72 hours after death with the Maryland Hygiene of other than "natural", or tiems 23a or 28a-f show any is, the Medical Esaminer must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County		City, Town or Location	on				10d Inside City Limits 1 X Yes 2 No
		10e. Street and Number	[Di	AHIMORE	10f. Zip Code		10	g Citizen of What Coun	
		1501 N. Pay		<i>F</i>	2121			USA	Latin Olash
death wi or items must be		11. Marital Status  1 Never Married 2 Marr	ied 12. Was Decedent Ever Armed Forces? 1 Yes 2	If Ye		ispanic Origin? ( in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	White, etc.	
urs after tural", o		3 Widowed 4 Divor	ped if Yes, Give Year or Dates: y only highest grade complete	ed) 16a. Decedent		ation (Give kind o		Specify: 16b. Kind of Business/h	CAN AMERICAN
21215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner		Elementary/Secondary (0-12)	College (1-4 or 5+)	01	ost of working life nunport	e. DO NOT use re	etired)	MA Dona	rids
21215-0036 nuld be filed within 7 Mental Hygiene marked other than c event, the Medics		17. Father's Name (First, Middle, L		11/25/0		18.Mother's Nar	me (First, Middle, M	Maiden Surname)	
212 Id be Menta narke		19a Informant's Name/Relationship		19b. Mailing	/		r Rural Route Num	ber, City or Town, State	
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		Manifa Doc. 20a Method of Disposition	ne - Mother	20b. Place of Disposi			DAH mc	20c. Location - City or	
Baltimore, permit Pages I a Department of He Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Special		crematory or oth	Zion	00	Abox 18,200	LANSdo	one. Md.
Balti permit Departm Imports injury o		21. Signature of Funeral Service Li	censee	22, N NAA	ame and Address	s of Facility	Cunona	MIC MARY	Ard
Physician		23a. Part I. Enter the disease, or or failure. List only one cause or		leath. Do not enter th	ne mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	r	Immediate Cause (Final disease or condition resulting in death)	a. Bilateral Pulmonary  Due to (or as a consequer		lism				Death
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Deep Venous Thrombosis of Lower Extremity  Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
760, icate be executed physician and the burial - transit		d.							
60, ate be ex ohysician e burial	Medical	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of	pregnancy				23d. Date of delivery	
Aecords, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	sician/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	2 Fet	tal death 3	Ectopic preg	inancy	Month E	Year Year
P.O. Box 68: that the death certifined by the attending detached for use as it	Physi	Yes 2 No 9 Unkn	9OTIKITOWIT			gwen in Part I	23e Did to	bacco use contribute to	the cause of death?
ords, P.O. w requires that th as been signed by should be detach	þ		to continuing to death but	Thor resulting in the d	miderly mg dadac	gitoriii arti		2 No 3 Prob	
ords aw requi as been 2 should	Completed						24a. Was a autop	sy prior to c	topsy findings available ompletion of cause of
									s 2 No
Vital hysician: this certif	0 B	examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6   Other							
ion of tending Pt eath. tor: After the funeral	tion: T	27. Manner of Death  1 Natural 5 Pendir		28b. Time of Ir	, manual	ury at Work? Yes 2 No	28d. Describe h	now injury occurred	
Division of Vital Records, pital or Attending Physician: The law require and a sfer death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	2 Accident Investi 3 Suicide 6 Could	not be 28e. Place of Injury -	- At home, farm, stree	et, factory, office	building, etc.	28f. Location (S or Town, S	Street and Number or Ru	ral Route Number, City
Hospi 24 hou Funer stely fil	Medical Cer	4 Homicide determined (Specify)  29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started							
To the Hos within 24 h To the Fur completely		one) 2 Medical Exam 29b. Signature and title of certifier	iner:On the basis of examinat and manner stated.	tion and/or investigat		on, death occurre	d at the time, date	and place, and due to th	
		Pot Clian	16-ROD.	h		.M.E.		October 11, 2006	
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	tate	31. Date filed (Menth-Day, Year)	2006 32. R gistrar's Si	ignature	ente.				
Regis	uteli		LUUU Jast Harris	1 10 19					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	ealth and Death	Reg	en@ 006		
Physic	ian	Decedent's Name (First, Middle, Last     SOPHIA	)	BLOCK			2. Date of Death	13, 2006	3. Time of Death  1:30 A M	
/Medi		4a. Facility Name (If not institution, give	street and number)	DI		Location of Deat		4c. County of Dea		
Exami	ner	3409 COURTLEIGH				BALTIMO	1			
Funeral	П	Social Security Number 6. Se	HIV	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Biri	thplace (State or Foreign puntry) TENN	
Director		Usual Residence of Decedent  10a. State  10b. County	Λ 03	y, Town or Lo	ocation		11/13/19	10	10d. Inside City Limits	
se Mary Ba-f eho	Director	MD BALTI	MORE	BAL	TIMORE				1 ☐ Yes 2X No	
h with the	ai Dire	3409 COURTLEIGH	DRIVE #A		10f. Zip Code	21244	109	g. Citizen of What Co	ountry? USA	
deet F	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-	14. Race - Ame		
1215-0036 within 72 hours after deeth with the Maryland ene. then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	o rican, etc.)	Black, Whit	WHITE	
15-0	ietec	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wo	rking 16	b. Kind of Business	/Industry	
21215-0036 od within 72 hours affigiene. The mature!; or the Medical Evan.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SECRE		,		OWN BUSI	NESS	
ire, Maryland 21215-0036 s 1 end 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 show other treumatic event. The Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  NATHAN  BLACK  18. Mother's Name (First, Middle, Last)  MIRIAM					Maiden Sumame) SMULYAN			
end 2 sho ealth and m 27 le m		19a. Informant's Name/Relationship (T) BARBARA BLOCK /		1	-		ural Route Number, C STERSTOWN	•		
altimore, rmit. Pages 1 er pertment of Hea portant: If teem y Injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		lace of Dispo emetery, crer	sition (Name of matory or other place	<b>9</b> )	Date 20	c. Location - City or	Town, State	
Baltimol permit. Pages Depertment of Important: If it any Injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	HAF	1	TIFERATH  Name and Addres		0/13/2006	ROSEDAI		
Deperment of the population of		Acoto M.	Cuttle			3	OL LEVINS		., INC. , MD 21208	
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	h. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arres		Approximate Interval Between Onset and Death	
Examiner	niner	Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
8760, at the best of the second and the burial-transit	lical Examin	that initiated events of the control								
Records, P.O. Box 68 The law requires that the death certificat te has been signed by the ettending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 morths?  1					23d. Date of delivery Month Day Year			
s that the ned by	by Ph						co use contribute to the cause of death?			
COTGS, P w requires that been signed to should be deta		- INANITION 1 Yes				2 No 3 Probably 4 Unknown				
	Completed						24a. Was an autopsy performe	g2 prior to death?	utopsy findings available completion of cause of 2 No	
f Vital F ysician: Th us certificate director, pag	Be	25. Was case referred to medical examiner?			1.0		ath (Check only one)			
Of \Physic this c all dire	은	Tes 212 No				ome 5 Residence 6 Other (Specify)				
vision of Vital Attending Physician: r death. ector: Alter this cartifice by the funeral director, I	ation:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?  M 1 Yes 2 No		Work	(?	28d. Describe how injury occurred			
Divis	Certification:	3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Division  • Hospital or Attendi n 24 hours eller deeth. • Funeral Director: bletely filled in by the fu	Medicai (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the I within 2 To the I complet	Me	29b. Signature and title of certifier 29c. License number 29d. D					4	Date signed (Month, Day, Year)		
July MI 2000 4701								10/13/00		
20	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SIMALING 3635 Old Cout Rd.									
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture"	8.0 P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 32573 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2,55 P M 13 06 Florence Coldiron /Medical Elaine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin

5. Social Security Number Square Hospital Center imore Rosedale 1 Year | If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2X F Director 140-24-4421 1/24/1933 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐XNo **Funeral Director** Maryland Baltimore Middle River 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "C" 9801 Langs Road Apt 21220 S. A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and 2 should be fill Heelth and Mental H tem 27 is marked ott diron, 2 Joseph O'Donnell Marion Shellenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i 309 Holly Hill Road Brian Horton (Son) Reisterstown, MD 21136 permit. Pages 1
Department of He
Important: if iten
eny injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17 2006 Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Es 23a. Part1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Intracrania /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ibrillation 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed tension 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No : After this certifice s funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation nours after death.
neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 29a Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and trianner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D000 55107 10/13/06

Registrar

DHMH 17 Rev 1/2001

DK, William K 31. Date filed (Month, Day, Year)

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Franklin Square Drive Baltimore MD, 21837

06-07720 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene John R. Carter 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 14, 2006 1344 hrs Medical Examiner John Ruben Carter, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 12096 Long Lake Drive Owings Mills **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country Months Days Hours Director Sep. 23,1963 Maryland 263-97-5096 43 **X**XM 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2XX No 28a-f show Baltimore Owings Mills MD with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 12096 Long Lake Dr. 21117 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' XX Never Married 2 Married Yes XX No White after Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Perent of Health and Mental Hygiene.

Int: If item 27 is marked other than "n MD 21215-0036 Chef Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) (unknown) æ John Jane Carter 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic Milton Marriott / Cousin 18 Wengate Rd. Owings Mills, MD 21117 20c Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State mportant: 10/16-06 Metro Crematory Inc. Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills,MD211**1**7 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Alcohol abuse Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED AMENDED #1,23a-b, PII,27,perME, g862, 12/7/06 tT Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 Unknown Seizure disorder Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has l performed? . death? 1 🗸 Yes ✓ Yes 2 No 2 No certificate 25 Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other \_ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes After this ဥ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within ? 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and O.C.M.E. October 15, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCT

	-	For State Registrar	State of	f Maryland	l / Depa <i>Cei</i>	artment rtificate	of H	eaith a Death	ina Me		leg. No.	2006	32	2575
		1. Decedent's Name (First, Middle, La	ist)						2	2. Date of Dea Month	th Day	Yea	r	ne of Death
Physicia /Medica			Eva (	Cathcart					C	ctober	7,	2006		50 P
Examine		4a. Facility Name (If not institution, given		nber)		4b. City,	Town, or	Location of	of Death		4c.	County of De	ath	
	9	12401 Lime Kiln				Ful		If I lades	04 Has I a			ward		
uneral			Sex 1 □ M 2 Ž F	7. Age (In yrs. la		If Under Months	Days	If Under Hours	Min.	3. Date of Birth (Month, Day	( Yeer)		Birthplaca <i>(St</i> Country) SS1SS1	
irector	-	Usual Residence of Decedent		8	0	li			J	an. 6,	192	6 1111	221221	ррт
* ==	1	10a. State 10b. County		10c. City,	Town or Lo	cation				····			10d. Insid	de City Limi
4 E	ţō	MD Montgom	erv	Si	lver s	Spring	7						10	Yes 2XXN
or 28a-f show be notified at	Director	10e. Street and Number	011		1701	10f. Zip				1	10g. Citiz	zen of What	Country?	
23a o	0	2011 Sullivan L	ane			20	0906					USA		
natural, or itams 23a	Funeral	11. Marital Status	T	edent Ever in U.S	3. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spec	ify Yes or No- ican, etc.)	1	4. Race - Ar Black, W	merican India	ın,
or ita	2	XXNever Married 2 ☐ Married	1 Tes	2 XNo		1 ☐ Yes 2			1, 1 0010 1	ouri, bic./	i	Specify: V		
E	d b	3 Widowed 4 Divorced	Year or D	ates:		10 103 2	- 24 110	Броспу.						
natural dical Ex	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usua kind of wor	k done c	turing mos	t of working	,	16b. Kir	nd of Busines	ss/Industry	
r than	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us								
other than vent, the Me		12th	Ø		Surg	gical	Nur		ric Nama (	First, Middle.		pital		
- T	Be	17. Father's Name (First, Middle, Las.									. neiueii	carraine/		
is marked of	ို	Martin Keith C			405 M-95		/Ctro at 4			Blake Route Number	. City or	Town State	Zin Codol	
1 e u		19a. Informant's Name/Relationship									-			
or other treumatic		Jenny Culver/Sis	ter	20b. Pla					, Sll Da	ver Spi		-	2090 <u>6</u> or Town, Sta	te
n	Н	1XXBurial 2 ☐ Cremation 3		Siale	ace of Dispo				10/10					
tant jury		*4 □Donation 5 □Other (Speci		Par	klawn					/2006 aldson				D 7
Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee	_M00160						Laure			•	r • A •
		23a, Part 1. Enter the disease, or con	exications that o	74									Approx	rimate
ysician Medical aminer		shock, or heart failure. List only timmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. <u>Ao A</u>			الده/						-		and Death
nysician and he burial-transit	al Examiner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	(or as a consequ										
a t	edical		d						-					
by the attending p tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live b	come of pregnar pirth 2  Fetal pant at time of de pown	death 3	⊒Ectopic pr ⊒ Other (sp					2	23d. Date of o Month	delivery Day	Year
gned b	by Pt	Part II. Other significant conditions	contributing to d	eath but not resu	lting in the u	inderlying c	ause givi	en in Part I		23e. Did to	bacco u	se contribute	to the cause	e of death?
										1 🗆 Y	es 2	⊒No 3□	Probably	4 Unknov
2 should	Completed									24a. Was a		24b. Were	autopsy find	lings availat
ate has	E C									autop: perfor 1  Yes	med? 2 Ho	death	to completion i? 'es 2□ No	
certificate rector, pag	ပို	25. Was case referred to medical						26 Place	of Death	(Check only or		,,,,,	63 20 140	,
	0 13	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆 E	ER/Outpatie	nt 3 DC	A Oth	051		e 5 Resid			SONO L	IVW4
E -	F .	27. Manner of Death			28b. Time o		8c. Injun	y at		8d. Describe h			CAN	WE CAN
in. : After s funer	흹	1 Patural 5 Pending 2 Accident investigation		in, Day Yeer)	Injury	м	Worl	Yes 2	No					
within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral completely filled in the funeral completely f	Certification:	3 Suicide 6 Could not determined	d 200. Place	of Injury - At hoing, etc. (Specify		reet, factory	, office		28	Bf. Location (S City or Tow			Rural Route	Number,
e Funer letely fill	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 1 ☐ Medical Exe		best of my know asis of examinat ner stated.	wledge, deat ion and/or in	h occurred ivestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ar ith occurred	nd due to the d d at the time, d	cause(s) date and	and manner place, and c	as stated. due to the ca	use(s)
<b>≒ 5</b> €	Me	29b. Signature and tiple of certifier						e number		1			onth, Day, Ye	
I S C		\ \\/\lambda \/					~	101			A .			
To		×12	ho			1	05	1860	,		OC	10BEA	7.2	006
Con Con		30. Name and address of person who	completed caus	se of death (Item	23a) (Type.	Print)	05	1860	,	Con	00	TOBER	7,2	00 6

			1 - For State Registrar	State of Man	yland / De <i>C</i>	partme <i>ertifica</i>	nt of H te of L	ealth and l Death	Mental Hy	giene Reg. No.	006	32576
	Physici	an	Decedent's Name (First, Middle, Li	1 . 1					2. Date of De Month	Day		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi	COLE JR.		4h Cih	( Town or	Location of Deat	OCT	8	200 County of Deat	
	Examin	ier		F MARY LAW	> MENIC		0 1-	IMORE	"	40.	County of Deat	,,
	Funeral		5. Social Security Number 6.	Sex 7. Age (I	n yrs. last birthda	ay) If Und	er 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Sept 6	th Vear	9. Birt	hplace (State or Foreign
	Director			1 M 2 □ F 7	5 Yrs	Months	Days	Hours Min.	Sept 6	19	31 Ma	ryland
3	2 *		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or	Location						10d. Inside City Limits
3	f eho	lor	MD Prince	George's	Laure	1						1 ☐ Yes 2√⊡No
-	r 28a	rec	10e. Street and Number			10f. Z	ip Code			10g. Citi	izen of What Co	untry?
1	23a o	Funeral Director	15400 Clayburn D	rive			20707			U.	S.A.	
1	eme Film	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	1	3. Was Dec	edent of His	spanic Origin? (S n, Mexican, Puer	specify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, White	
	lines within 7.2 hours after bean with the maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f show ent, ite Medicel Examinat must be notified at	by Fi	1 ☐ Never Married 2XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 XXes 2 □ No If Yes, Give Year or Dates:	1950- 1954	1 🗆 Yes	2 <b>XX</b> 0	Specify:			Specify: Wh	ite
3	sture!		15. Decedent's B	ducation	16a. De	cedent's Us	ual Occupa	tion		16b. Ki	ind of Business/	Industry
וֹ כּי	O D	plet	(Specify only highest gi	College (1-4or 5+)	(G life	ive kind of w e. DO NOT	rork done d use retired,	uring most of wo	rking			·
V .	or the	Completed	Grade 12		Aı	nalyst	:			U.S	. Gover	nment
	modic per mac within and Mental Hygiene.  marked other then imatic event, it a Ma	Be	17. Father's Name (First, Middle, Las William Laurence						me (First, Middle		Sumame)	
7	marked c	٩		·	101 14		(2)		sa Morga		T	
≌ ເ	a e a		19a. Informant's Name/Relationship Dorothy E. Cole	/ wife		-			ural Route Numb Laurel			20707
ю,	Health tem 27		20a. Method of Disposition		20b. Place of Dis		_	The state of the s	Date		ocation - City or	
	Definit. rages Department of h Important: if its any injury or of once.		1XXBurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		Meadowr				3/2006	Do	rsey, M	aryland
airiiio	partm portai		21. Signature of Funeral Service Lice			22. Name	and Addres	s of Facility	1 Home,	Dλ		
<u> </u>	Depa impo any i		Danie Van	uldar MOOI	60							d 20707
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the y one cause on each line.	e death. Do not	enter the mo	ode of dying	, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
	hysician	1	Immediate Cause (Final disease or condition	a. //·	1POXIE	4						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						-		
		20	Sequentially list conditions,	b. Oue to for se a o	PUMON							
2	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ASTA	ROCIT	oma						
5	physician and the burial-transit	Еха	resulting in death) Last	Due to (or as a co								
,00,00	nysici he bu	dlcal		d								
5	ing pl	Med	IF FEMALE:	00-14								
	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 Ectopic				1	23d. Date of del Month	ivery Day Year
5	y the ched	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ie or deali	o □ Otner (:	spacity)	7,555	117.			
	ned by deta	by Pr	Part II. Other significant conditions	contributing to death but n	ot resulting in the	e underlying	cause give	n in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
3	on sign								1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
5	scertificate has been sig director, page 2 should b	Completed							24a. Was		24b. Were au	stopsy findings available completion of cause of
	ate ha	mo(								ormed?	death? 1 ☐ Yes	
	entific actor,	Be (	25. Was case referred to medical examiner?	The control					ath Check only	оле)		
5	this c	P.	1 ☐ Yes 2 No 27. Manner of Death	Hospital:	2 ER/Outpa			4   Nursing P	dome 5 Res			cify)
5	After funer	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injur	y M	28c. Injury Work	at ? ′es 2 ∐No	28d. Describe	now injur	y occurred	
2	deat ctor: y the	ertification:	3 Suicide 6 Could not	28e. Place of Injury	- At home, farm,				28f. Location (	Street an	d Number or Ru	iral Route Number,
5	s after	Certi	4 Homicide	building, etc. (	Specify)				City or To	wn, State	)	
1	withing hospital or westings higherent. The taw requires that the beath certain to the transfer death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		7.35 Certifier 1. Certifying P	hyniciam: To the best of m miner: On the basis of ex	ny knowledge di amination and/or	sath occurre	d at the tim	e, data and plane	and due to the	causa(s)	and manner as	stated.
1	hin 24	Medical	one)	and manner stated	1.							
*	Co To	-	29b. Signature and title of certifier	1		2	9c. License				te signed (Monti	
	$\cap$		C Zerl	e MID	h (Itam na-) cr	no Deier		858			78	2006
	1.1		30. Name and address Tperson who	22 SoyT/1	GREEN	ve Si	REET	BAITI	nort.	MD		
	Sta	ite	31. Date filed (Month. Day, Year)	2006 32. Registrar's	Signature	Lock	9					
	Registr	22	1161107	UUU   A Mallo Ad	1 250 1	LIXAD BO	gran a					

			For State Registrar	State of Ivially	riand / D	repartmen Certificat	e of De	aith and i eath		Reg. No.	32577
4	5		1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath Day Year	3. Time of Death
	Physicia /Medic		Bernard Joseph Ca	valera					OC TOBE		
	Examin	-	4a. Facility Name (If not institution, giv	e street and number)				ocation of Death		4c. County of De	ath
			GOOD SAMAR	17AN 170	SPITAL	- B		MORE			
	Funeral		Social Security Number 6. S	MA OFF	yrs. last birtl	Months		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year) 9. Bi	irthplace (State or Foreign Country)
	Director		219-34-6381	8.	2 Y	rs.			08/20	/1924 NY	
	pur w	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location					10d. Inside City Limits
	faryla sho	ō	NO. 7.11.								1 ☐ Yes 2 ♣ No
	28a-	ect	MD Baltimo  10e. Street and Number	re 1	Essex	10f. Zig	Code			10g. Citizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show criust be notified at	Funeral Director		d 3nt 20		212				United Sta	tes
	ns 23	era	202 Middleway Roa  11. Marital Status	12. Was Decedent Eve	r in U.S.			anic Origin? (Sp	pecify Yes or No Rican, etc.)		nerican Indian,
0	riter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces?					o Rican, etc.)		
2-003e	i within 72 hours after death with the Marylan liene. I than "natural", or Items 23a or 28a-1 show the Madical Examinat must be multied at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>10</b> No 3	Specity:		Specify: Wh:	ite
ဂ ဂ	72 hc	sted	15. Decedent's E (Specify only highest gra		16a.	Decedent's Usu	al Occupation	on ina most of wor	kina	16b. Kind of Busines	s/Industry
N	within 72 ene. than "nai	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of wo life. DO NOT u	se retired)		3	Trucking	
N	filed w Hygier ther th	Completed	12		Trı	ıck Driv			/F:	44.14 6	
	0 = 0 ×	Be	17. Father's Name (First, Middle, Last	)						, Maiden Sumame)	
yıan	should and Men a marke umatic	ျ	George Cavalera						rgori	0: T 0:	7.0.4
Mar	C1 00 = 10		19a. Informant's Name/Relationship ( Mr. Anthony Joseph			3				er, City or Town, State,	
	1 and Health Bm 27 ther to		20a. Method of Disposition					oro Road	Date	20c. Location - City of	
و	ages or o		1 ☐ Burial 2 ☐ Cremation 3 ☐	Judinoval itom State		Disposition (Na y, crematory or o			Oct 16		
Baitimore,	it. Partment		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	200		eake Cr			2006	Beltsville,	Maryrand
g	permit. Pages Depertment of I Important: If Ite any Injury or of		1 Stule	I Mo	5986	Cremat	ion and	d Funera	l Altern		1 1 21206
۰	_		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the	death. Don	ot enter the mod	reen Pa	astures such as cardiac	or respiratory a	<b>altimore, Ma</b> rrest,	Approximate
	Dhuaisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		0= 0.0	3 4>		7		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	nsequence o	non:	(H 10)	7 F	AILUIC	۵	
	Examiner			CHRON	111	OBST	RUCT	100	PULMON	2 SARY DISC	
Ą		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence o	of):			000000		1,6
	cuted nd ransi	Examiner	that initiated events	C							
Ď,	te be executed ysicien and te burial-transit	Ë	resulting in death) Last	Due to (or as a co	onsequence o	of):					
8/60	ficate be executed physicien and is the burial-transit	edical	•	d							
9	ing p	Med	IF FEMALE:								
X R O	deeth certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 □Ectopic p				23d. Date of d Month	lelivery Day Year
-	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tim 9□ Unknown	e of death	5 Other (s	эөспу)				
J.	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying	ause given	in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
ecords,	signed to be det	d by	CHRONIC A	ENA F	ALLIN	6			1 🗆	Yes 2□No 3€	Probably 4 Unknown
Ö	w require been sig should t	ete							24a. Was	an 24b Were	autopsy findings available
ĕ	The lay	Completed	OBSTRUCTIO	6 SCETE	D H	PREF			auto perfe	psy prior to death	o completion of cause of ?
of Vital H			25. Was case referred to medical				2	OC Disease of Day	1 ☐ Yes		es 2 No
5	sicien: certifica irector,	o Be	examiner?	Hospital:	2 ER/Ou	tpatient 3 De				idence 6 □Other (Sp	nacify)
0	ig Physiter this neral di	To It	27. Manner of Death	28a. Date of Injury	28b. T	ime of	28c. Injury at			how injury occurred	
<u>o</u>	th. : After s tuner	tloi	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	e <i>ar)</i> Ir	njury M	Work? 1 ☐ Yes	s 2 🗆 No			
Division	Attendi r death. ector: A by the fu	ifice	3 Suicide 6 Could not to determined		- At home, fa	rm, street, factor	y, office		28f. Location (	Street and Number or wn, State)	Rural Route Number,
ā	s afte	Certification:	- Individue	building, etc. (	эрвену)					, 5.4.6)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificicompletely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of n	ny knowledge amination and	, death occurred	at the time,	date and place	, and due to the	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	the hin 24 the F	Medical	one)	and manner stated	//						
	To To Con	2	29b. Signature and title of certifier	M	1 -		c. License n		)5	29d. Date signed (Mo	
•			PHYSICIA			1	) (1)	000	1	UCCOBO	1 3 2006
	1		30. Name and address of person who		h (Item 23a) (	Type, Print)	000	MARGIT	Ton 1	werdself	ВАТІМОР
	V		MAW NAING 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	000	) 3/		mN 1	- JIIIL,	DIAZIMOR
200	Sta										

			1 - State Amend item#2,29d		of Maryl 3860, 10	and / Dep /18/06 <b>&amp;</b>	artment of I	Health <i>Deatl</i>	and M	lental Hygi	ene2 0	06	32578
	Physici /Medio		1. Decedent's Name (First, Middle, Las Ida		Mae		Ca	arte	•	2. Date of Death Month Crober	Day 11	Year <b>2006</b>	3. Time of Death 0 129 A M
	Examir	er	4a. Facility Name (If not institution, give Since Hospita	f of	Balti		4b. City, Town, Bolfin	ore	city		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Security Number 9 6. Security Number 9 10 11 11 11 11 11 11 11 11 11 11 11 11	х ]м <b>Ж</b> ДГ	7. Age (In )	rs. last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, 04 13	<sup>Yea</sup> r)25	9. Birthp	place (State or Foreign htry) MD
	Maryland s-f ehow	tor	10a. State 10b. County MD NA			City, Town or Lo						1	0d. Inside City Limits 1   Yes 2   No
	s or 28e	I Director	10e. Street and Number 4505 Finney Ave				10f. Zip Code	1215		10	g. Citizen of W		ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hyglene. Important: if item 27 is marked other than "natural", or itams 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinant handlind at ADGE.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was De Armed F	2⊠No Sive		Was Decedent of If Yes, specify Cut	Hispanic C ban, Mexic	an, Puerto	ocify Yes or No- Rican, etc.)		- Americ c, White,	an Indian, etc.
21215-0036	within 72 hou ane. Ihan "natura Ia Madical E	Completed	15. Decedent's Ed (Specify only highest grad	ucation le completed College		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mo		ng B	6b. Kind of Bu	ore	City
Maryland 2	uid be filed v Jental Hygle rked other i tic event, II	To Be Co	12th grade  17. Father's Name (First, Middle, Last)  Roy Holmes	na			eachers!	18. Mot	her's Name	(First, Middle, M	Chool		cem
Baltimore, Mary	1 and 2 sho fealth and 1 om 27 is ma ther trauma		19a. Informant's Name/Relationship (7) Ruth Annette Ca 20a. Method of Disposition				ng Address (Stree		Bal	ltimore	, Md	212	07
	nit. Pages artment of Portant: if its injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	1	n State	cemetery, cre. Garrisc	n Fores	st V	et. ]		oc. Location - (		Mills, Md
Ba	Depariment impo		23a. Part1. Enter the disease, or comp	elmor	nch	43	Name and Add Irch F/F	ash A	Ave,			id	21215 Approximate
	Physician //Medical Examiner pub sicieu und physicieu und	dical Examiner	shock, or heart laiture. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a con		Tach	per	dia	ş, dn			Interval Between Onset and Death
.O. Box 6	Physician: The law requires that the death certificate that been signed by the ettending at director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🗆 Live	utcome of pre birth 2   F gnant at time on nown	etal death 3	Ectopic pregnance Other (specify)	ey .			23d. Date Mon		Day Year
<u>α</u>	w requires that been signed b should be deta	۵	Part II. Other significant conditions co	ntributing to	death but not	resulting in the u	nderlying cause g	ven in Pari	:I. =	23e. Did toba	_		ne cause of death? ably 4 \(\sum \text{Unknown}\)
Vital Records,	ding Physician; The law re h. After this certificate has be funeral director, page 2 sh	Completed								24a. Was an autopsy perform	ed? p	eath?	psy findings available inpletion of cause of
Ĭ.	ysiciar is certif director	To Be	25. Was case referred to medical examine?  1 1 s 2 No	Hospital:	Inpatient 2	2 FERVOutpatier	nt 3□ DOA Ot	hor		Check on vone		r /Snacih	41
Division of	ting After fune		27. Manner Death  1 Chatural 5 Pending 2 Accident investigation	28a. Date		28b. Time o	f 28c. Inju		2	28d. Describe hov			0
Dİ	To the Hospitel or Attending within 24 hours efter death.  To the Funarei Director: After completely (illed in by the fune.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	build	ding, etc. (Sp.	ecify)	reet, lactory, office			281. Location (Stre City or Town,	State)		
	he Hosp n 24 hou he Funa pletely fi	Medical	29a. Certifier 1 Certifying Phy (Check only one)	mer: On the	ne best of my basis of exam nner stated.	knowledge, deat ination and/or in	h occurred at the t vestigation, in my	ime, date a opinion, de	and place, a eath occurre	and due to the car ed at the time, da	use(s) and mar te and place, a	nner as st nd due to	ated. the cause(s)
)	To t To t	M	29b. Signature and title of certifier  Rule VI Grant	de,	NO			se number		29	d. Date signed	11	Day, Year) 2006
_	4		30. Name and address of person who co	pues,	use of death (	Item 23a) (Type,	Hospi	MI	se é	BAUTION	ORE		
	Sta Registr		31. Date liled (Month, Day, Year)  OCT 1 6 21	106 32.	Registrar's Si	gnature							

ft Known As: Ido

M

		4	1 - For State Registrar	te of Maryland / Depa <i>Cel</i>	artment of H			ene_2006	32579
	Physici /Medio		1. Decedent's Name (First, Middle, Last)		DES.	41"	2. Date of Death Month	Day Year 10, 200C	3. Time of Death
_	Examin Funeral Director		5. Social Security Number 6. Sex	7. Age (Irl yrs. last birthday)	4b. City, Town, or  If Under 1 Year  Months Days	Location of Death  WOWE  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Y Feb 17,	4c. County of Death  n/a  ear) 9. Birthp Cour	olace (State or Foreign ntry) India
	how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			1	Od. Inside City Limits
	th the Ma or 28e-f	Directo	Maryland Howard  10e. Street and Number	H	ighland 10f. Zip Code		10g	. Citizen of What Cour	1 ☐ Yes 2X No
	death wi	Funerai [		s Decedent Ever in U.S. 13.	2077 Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	United St.	can Indian,
036	ours after ral', or ite Exemine	þ	1 Never Married 2 Married 1 If You	Yes 2X No		Specify:	nican, etc./	Specify: As	ian-Indian
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23 a or 28s-f show or other treumatic event, Its Madical Examinatinatal by notified at	Completed	15. Decedent's Education (Specify only highest grade composition) Elementary/Secondary (0-12) Coll	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work )	ing	b. Kind of Business/In	
	ti Hygier other th	Be Cor	17. Father's Name (First, Middle, Last)	5+ Ow	ner/Presi		E: e (First, Middle, Ma		Consultant
Maryland	should be nd Mental marked o	ToE	Ashwinkumar Desa		ng Address (Street a	Virbala	Laxmanr	ai Thakor	(Code)
	i and 2 sho Health and Im 27 ie mu iher treums		Ila P. Desai/wife	13462	Charolai	s Court	Highland	, Maryland	20777
Baltimore,	Pages ment of h ant: if its ury or of		1 ☐ Burial 2\(\sum_{\text{C}}\) Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	i irom State	osition (Name of matory or other place del Crema	,		Odenton, M	
Balt	permit. Page Department Important: If any injury or once.		21. Signiture of Funeral Service Licensee	1	<sup>2. Name and Addres</sup> onaldson 411 Annap	Funeral lolis Roa	Home & Cr d Odento	ematory, P n, Marylan	.A. d 21113
,	Physician /Medical Examiner		23a. Part) Enter the disease, or complications shock or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not end on each line.  Ohal Anckee Kouse to (or as a consequence of):	ter the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
S	kecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	rue to (or as a consequence of):	Afrium,	linfax:0	L VOLLA	CAVA	lday
68760,	icate be executed physicien and s the burial-transit	cal	C <sub>0</sub> I	diopathic Ca	adionyo	eathy -	LUL	CAL EXAMINERS	13 46465
P.O. Box (	law requires thet the death certific as been signed by the attending p a 2 should be detached for use as	Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)	CERTIFICATION	APPROVED BY MEDI	23d. Date of delive Month	ery Day Year
	quires thet n signed b uid be deta	ρ	Part II. Other significant conditions contribution	ig to death but not resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute to to	he cause of death? pably 4 Dunknown
Reco	The law require ate has been si page 2 should I	Completed					24a. Was an autopsy performe	prior to co death?	ppsy findings available impletion of cause of
Vita	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?		ot 317 DOA Othe		h (Check only one)		
Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: Attenthis certificate his completely filled in by the funeral director, page	Certification; To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	Date of Injury (Month, Day Year)  Date of Injury (Month, Day Year)	f 28c. Injury	4 🗆 Nursing no	28d. Describe how	ce 6 Other (Special injury occurred to the attention because of the control of th	ntera verk
DİXİ	s after du Direct	Certific	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		City or Town, .	et and Number or Run State)	
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, deal in the basis of examination and/or ind manner stated.	th occurred at the time execution, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
-	within To the compl	Me	29b. Signature and title of certifier		29c. License	e number	1	d. Date signed (Month,	
	10		30. Name and address of person who complete	d cause of death (Item 23a) (Type	Print) /	5-000		Hober 10,	700 P
	ري ري		THUOR Ellison,	600 N. WOI	Fe Sti	BAltin	0.5 Mi	124/and	21287
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 1 6 2006	32 Registrar's Signature	made 1		,	-	

ORIGINAL

State of Maryland / Department of Health and Mental Hygien [ ]

32580 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:35 PM M Irene Pittman Dawson October 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14334 Chesterfield Rd. Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/11/1946 Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F 60 130-38-4799 Yrs Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 10a. State 1 ☐ Yes 2 No MD Montgomery Rockville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rthen "natural", or Iteme 23a or tre Medical Examiner must be 20853-14334 Chesterfield Rd. United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Private Education other then Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental h Pages 1 and 2 should be Edwin James Pittman Irene Manning Agatha VanDenfange 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 le
eny injury or other trau Edward F. Dawson/Husband 14334 Chesterfield Rd. Rockville, MD 20853-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 10/12/2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services mo1358 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Progressive Metastatic Breast Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown 9 Unknown ۵ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💯 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA (his Director: After th 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 / Homicide within 24 hours after To the Funerel Dire Certifying Physician To the bast of my knowledge, death occurred at the time, date and date at the cauce(c) and manner actuated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D066000 0 10/1/2006 30. Name and address of person who political cause of death (Item 23a) (Type, Print) Maujahed S. Achtar MD 8901 Wisconsin Ave Bethesda, MD 20889 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32581 State of Maryland / Department of Health and Mental Hygien [ ] [ ] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 13th Month **Physician** MICHAEL STEVEN EVANS 1:5/AM Oct 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE ST. AGNES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Sex 1MM 2□F Months Days Hours 49 213-66-7097 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State d 2 should be filed within 72 hours after deeth with the Maryla in and Mandal Hyglein. That merked class the state of the 1 ☐ Yes 2 No MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 5.5.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WhiTE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Heelth and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if item 27 is eny Injury or other trau 1445 WATTS AVE SEVERN, MD. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State ANATONYCHOTS REGISTRY 10-14-06 HANOVER, A 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund al Arvice Licensee 22. Name and Adress of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Bowel Perforation **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepatic En Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the ettending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete has all director, page 2: ours efter death. Jeral Director: After this certified filled in by the funeral director. Attending Physician: Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospital Cartifying Physician: To the heat of my knowledge, death occurred at the time, date and plane, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20659 13 2006

0 State Registrar

31. Date filed (Month, Day, Year)

OCT 1 6 2006

HAFSA KHAN STAGNES HOSPITAL, BALTMORE, MD. 21229 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

Box 68760,

Division of Vital Records, P.O.

			1 For State	State of Maryland	I / Depar	tment of H	ealth and	Mental Hy	giene	006	32582
			Registrar  1. Decedent's Name (First, Middle, Last)	-	Cert	ificate of L	Death	2. Date of De.	Reg. No.		3. Time of Death
	Physici			FURMAN				Month	Day	Year 2006	12:44 AM
1	/Medio Examir		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Dea			ounty of Death	
			Mercy Madica	1 Center	- 1	3alti	TMUN	× _	130	rLTI	MORE
	Funeral Director		5. Social Security Number 6. Sex 220 – 22 – 9307 1 □	7. Age (In yrs. la. 88		ff Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Cou	place (State or Foreign intry) MD
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loca	ation					10d. Inside City Limits
	Maryli f •ho	ō	MD N/A			ltimore	City				1,  Yes 2  No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?
	th witt	alD	1327 Hull Stree	et, Baltimor	e MD	21	230		Un	ited	States
	r dee	Funeral	11. Maritaf Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	. 13. W	as Decedent of Hi res, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14	. Race - Ameri Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2₹☐ No If Yes, Give Year or Dates:	10	□Yes 21 No	Specify:		Si	pecify: W	hite
21215-003	within 72 hours after deeth with the Maryland ans. Itan "natural", or Itema 23e or 28a-f ehow Ita Medical Examinar maat be notified at	ted	15. Decedent's Educ	ation	16a. Decede	nt's Usuaf Occupa	ation		16b. Kind	of Business/Ir	ndustry
215	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	nd of work done of NOT use retired	)	nrking			
2	filed w Hygier ther th	Co	1 0	0	H	omemake		me (First, Middle,	Maidan C		n Home
lanc	S ta b y	To Be	Felix Zaleski					ie Mosk			
Maryland			19a. Informant's Name/Relationship (Type Benita M. Furma		_			ural Route Number altimor			
altimore,	ges 1 and 2 tof Health If Item 27 or other tr	1	20a. Method of Disposition	) car	ice of Disposit			Date		ition - City or T	
Ē	mit. Pages partment of I portant: If It y Injury or o		1 ⊈Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		y Cro	ss Cem.	10	/17/200			
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	Victor Doda	Cha 1 5 0	Name and Addres arles L 01 E F	s of Facility Stev	ens Fun e., Bal	eral	Home,	, zInc
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not enter	the mode of dying	g, such as cardia	c or respiratory ai	rest,	TE MD	Approximate Interval Between
) }	Physician		fmmediate Cause (Final disease or condition	METUBO	LIC	ENC	CPWA	LOPAT	HY		2 weeks
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):			/			(3 0-1
		er	Sequentially fist conditions, if any, leading to immediate	Due to (or as a conseque	ence of):	NXL	1-A11	ure		-	-tweeks
77-	ud ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
,09	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
876	cate b physic the b	dicai	d.								
× 6	eath certifi attending I for use as	/Me	IF FEMALE: 23	sc. If yes, outcome of pregnance	cy				23/	d. Date of defiv	ren.
. Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐Fetal d 4☐Pregnant at time of dea		ctopic pregnancy Other (specify)			250	Month	Day Year
o.	y th	hys	9 Unknown	9□ Unknown							
Records,	200	Þ	Part II. Other significant conditions cont	nbuting to death but not result	ting in the und	erlying cause give	en in Part I.	23e. Did to			the cause of death? bably 4 DUnknown
000	aw require is been si 2 should l	Completed						24a. Was		24b. Were aut	opsy findings available
_	The lav ate has page 2	E O						autop perfo	rmed?	death?	ompletion of cause of 2 No
Vital	ding Physician: The In. After this certificate hat funeral director, page	Be	25. Was case referred to medical examiner?	nonital:	·	104		ath (Check only o	ne)		
of	Physic this cral dir	<u>유</u>	1 Yes 2 No		R/Outpatient 28b. Time of	3 DOA Othe	4   Nursing I	Home 5 ☐ Resid			fy)
O	Attending r death.	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	:? ∕es 2 ⊡No	Zou. Describe	iow injury c	Accuired	
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury - At hom building, etc. (Specily)	ne, farm, stree	t, factory, office		28f. Location (S City or Tox		Vumber or Run	al Route Number,
_	To the Hospital or At within 24 hours after C To the Funeral Direc completely filled in by	edicai Ce	(Check only 2 Madical Examin	ician: To the best of my knowl ar: On the basis of examination	ledge, death o	occurred at the time	e, date and place	e, and due to the	cause(s) ar	nd manner as s	stated. to the cause(s)
	thin 2 the 1 mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month,	
	8 4 8 4		Je Bros.		10						* * * * * * * * * * * * * * * * * * * *
	P,		30 N me and address of person who cor	mpleted cause of death (Item 2	<ul><li>(Type, Pr</li></ul>	rint)	-0 -6	- (	Myes	perl	2, 2006
	15	,	JUIN TBONKE	Wrum 3	0) 51	PAUL	Place	2 Bal	IMI	ME,	13, 2006
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 6 20	32. Registrar's Signatu	re :					Í	

State of Maryland / Department of Health and Mental Hygiene 1- Registrar Amend item#5, per Inf, G860, 10/25/06 Ertificate of Death 32583 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month **Physician** OCTOBER 7, HOYE WILLIAM FLETCHER 12:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 0563 506-12-0583 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1X M 2□F NEBRASKA 94 Director Sep. 21,1912 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lalury or other traumatic event; the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XTYes 21TNo Director MARYLAND ANNE ARUNDEL LOTHIAN 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 806 BAYARD ROAD 20711 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ Specify: 3X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PAINTER GENERAL CONTRACTOR 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LYDIA M. ARBOGAST JAMES A. FLETCHER ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 806 BAYARD RD., LOTHIAN, MD 20711 LARRY FLETCHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Buria! 2 □ Cremation 3 ☐Removal from State 4 Dopetion 5 Dother (Specify) BARTLEY CEMETERY 10/14/06 BARTLEY, NE 21. Sign rure of Funeral Service License 22. Name and Address of Facility
LOCKENOUR, JONES MORTUARY
P.O. BOX 27 CAMBRIDGE, N Lannis lun CAMBRIDGE, NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy rmea r 2 📉 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 X ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Fune (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 9, 2006 D29657 30. Name and add ress of Prson who completed cause of death (Item 23a) (Type, Print) 110 HOSPITAL RD., SUITE 310 PRINCE FREDERICK 20678 JUDGE, CHARLES 31. Date filed (Month, Day, Year) 32 Registrar's Signature State (grants) Registrar 6 2006

State of Maryland / Department of Health and Mental Hygier 006 State
Registra Amend #16a Per FH G860 10/16 Optificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 8, 2006 7:15 AM Jean Feagans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas Moore Nursing Center Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 12/02/1934 5. Social Security Number 7. Age (In yrs. last birthday)
71 Yrs 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Days Hours Min. 577-48-4838 MA Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked othar than "naturel", or Items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No MD Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782-4922 LaSalle Rd. United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT **Programmer**Computer Programmer 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Technology Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brigette Sutherlin/Friend 3715 49th St. NW Washington, DC 20016-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct 12 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Department of Important: If any injury or any injury or anger. Chesapeake Crematory 2006 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Kecurrent WX disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tyes 2 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed Human 1 Yes Hospitel or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending after death. Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 24 hours a 29a, Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 To tha ths 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10.09.2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TULI. Kainier, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) 6 OCT 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 0 Jane Keever Gans 2006 7:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Presbyterian Home of Md. Towson Baltimore 8. Date of Birth (Month, Day, Ye July 24, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1<sup>Year</sup> 1923 Months Days Hours Min. 1 □ M 2 V F 161-20-9457 83 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits Md. Baltimore 1 ☐Yes 2 No Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Keever Mary Gooch ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Gans, Jr./ Son 7107 York Rd. Baltimore, Md. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □Cremation 3 □Removal from State Dulaney Valley Mem. 10-18-06 Timonium, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funer Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1 1050 York Rd. Towson, Md. 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth of the course of the Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carchona disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an page 2 s autonsy performed? 1☐ Yes 2☑No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital war within 24 hours after death.
To the Funeral Director: After a consideral filled in by the fur 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

10

31. Date filed (Month, Day, Year) 6 2006

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St., Sate 4105, 15. 14hore, 200 21234 10

Attenday mo

32. Registrar's Signature

29c. License number

Octobe 16, 2006

Please Type or Print in Black Indelible Ink

rank J.	Giza, Jr	ĺ	For State Amend #20ate		P <b>epg</b> Cer	<b>/16706</b> tificate of	Health a Death	nd Me			Reg No.	200	32581
	Physicia Il Exami	34.0	1. Decedent's Name (First, Middle,Las FRANK J. GIZA,						1	2. Date of De Month October	Day	Year	3. Time of Death 2115 hrs
			4a. Facility Name (if not institution, giv 14 Wilson Boulevard Sout	e street and number)		4	ib. City, Town, Glen Burn		n of Death			unty of Death	)
	Funeral Director	А	5. Social Security Number 6. Se		(In yrs. Ia	ast birthday) Yrs.	If Under 1 Y	ar If Ur	nder 24Hrs. urs Min.		1 irth(MM/DD/Y 08/1950	Foreig	thplace (State or an untry) MD
	any	İ	Usual Residence of Decedent  10a, State 10b, County			Town or Locati	on						10d. Inside City Limits
		Director	MD ANNE AI			EN BURN				— Т	10g. Citizen o	of What Cou	1 X Yes 2 No
	the Ma a or 28 tiffed a	Dire	14 WILSON BLVD.	. SW			2106	1			USA		
	filed within 72 hours after death with the Maryland I Hygiene. Gother than "natural", or items 23a or 28a-f sh i, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent E Armed Forces?	ver in U. X No	If Y	s Decedent of I es, specify Cub	an, Mexic	an, Puerto F		0- 14. I	White, etc.	ican Indian, Black,
	72 hours afte n "natural" al Examine	Completed by	15. Decedent's Education (Specify o	or Dates:		16a. Deceden	t's Usual Occupost of working I	ation (Giv	e kind of w			of Business/	
0036	within giene. her tha Medic	dmo	12TH 17. Father's Name (First, Middle, Last			DRIVE	ER	18 Moth	ner's Name	First Middle	TRA		TRATLER
21215-0036	ould be filed within 72 h  Mental Hygiene.  s marked other than ",  ic event, the Medical F	Be C	FRANK J. GIZA,						LLIAN		Malacit Gan	iumo)	
D 21	permit Pages I and 2 should be file Department of Health and Mental H. Important: If item 27 is marked o injury or other traumatic event, the		19a. Informant's Name/Relationship (7	Type, Print )			Address (St	eet and N	umber or Re	ural Route N			
e, MD	Health attem 2		SUZANNE GIZA/WIF					emetery,	API'.	A DUN Date			
altimore,	Pages lent of l		1 Remial 2 XX Cremation 3 4 Donation 5 Other Specify			crematory or oth BAYVTEW		ORY	10/1	12/200			NNELL ST. . MD 21224
Balti	Departm Departm Departm Deports Deports Deports		21. Signature of Furleral Service Lice	nsee		22. N	lame and Addre	ss of Fac	ility WES	LEY CH	AVIS,	JR. FI	IRL. HM.
_	ysician		23a. Part I. Enter the disease, or com	plications that caused t	he death	Do not enter the	2007-09 he mode of dyir	g, such a	ERN A s cardiac or	respiratory a	rrest, shock, o	or heart	21231 Approximate Interval Between Onset and
- 1	Medical caminer		minimum datas (i mai allegar =	Gastrointestinal									Death
			or condition resulting in death)  Sequentially list conditions,	Due to (or as a conse	quence o	f):							
		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence o	f):							
,DB.	xecuted n and - transit	I Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence o	f):							
φ,	e be exer ysician a burial -	Medical 1	UNPENDED	AMENDED									
Division of Vital Records, P.O. Box 68760,	leath certificate e attending phy for use as the b	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcom  1 Live birth 4 Pregnant at the second of the second		2 Fe	tal death her (Specify)	B Ecto	ppic pregnar	ncy	23d. Da Mor	ate of deliver	y Day Year
O.	that the d ned by the detached	y Phy	Part II. Other significant conditions	contributing to death	but not r	esulting in the i	underlying caus	e given in	Part I				the cause of death?
Is, P	quires then signed ald be d	ted by	Chronic Alcohol Abuse	-						1 Y	es 2 ✔ No san [2		bably 4 Unknown utopsy findings available
Record	cian: The law re certificate has be ector, page 2 sho	Completed						(1)	ath (Check o	per 1 <b>Y</b> Yes	opsy formed?		completion of cause of
/ital	sician: nis certi director	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2	ER/Outpatient		Other <sub>4</sub>		g Home 5	Residence	6 🗸 Othe	r: Scene
on of \	Attending Phy er death rector: After the		27. Manner of Death  1  Natural 5 Pending 2 Accident Investiga	28a. Date of Inju (Month, Day,Ye	ry ear)	28b. Time of	· ·   _	njury at W		28d. Describ	e how injury o	occurred	
Divis	spital or Attendious after death neral Director: filled in by the	Certification:	3 Suicide 6 Could no determine	t be 28e. Place of Injudy						or Town	State)		ural Route Number, City
	To the Hos within 24 h To the Fur completely	Medical	29a. Certifier 1 Certifying Physic check only 2 Medical Examine	cian: To the best of my er: On the basis of exar	knowled nination a	lge, death occu and/or investiga	rred at the time tion, in my opin	date and ion, death	place, and occurred a	due to the ca t the time, da	use(s) and ma te and place,	anner as sta and due to tl	rted ne cause(s)
	To with	Mec	29b. Signature and title of certifier	and manner stated	2	. pr.		ense numb	per			er 9, 2006	onth, Day, Year)
	5		30. Name and address of person who Patricia Aronica-Pollak M				111 Penn	Street,	Baltimore	e, MD 212	01		
	_	tate trar	31. Date filed (Month, Day, Year)	32 Registra	r's Signat	ure	400						

			1 - For Amend #6 per	State of Marylar FH 6860 10/1	6/06-31	rtment of tificate of	Health and Death			32587
	Physici /Medic	***	Decedent's Name (First, Middle, Lase     ELLONA	t)	G	RABCHEN	<b>(</b> 0	2. Date of Death	Î Î Î 2006	3. Time of Death 7:30 P M
,	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, OWINGS	or Location of Dear	h	4c. County of De BALTIM	eath
	Funeral Director		212-39-0014	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs		105	Birthplace (State or Foreign Country) RUSSIA
	death with the Maryland ms 23a or 28e-f show rmust be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD BALTIM		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	i Director	10e. Street and Number 24 LOOMIS COURT			10f. Zip Code 21117		10	og. Citizen of What	
036	be filed within 72 hours after death with the Marylan del Hygiene.  del Hygiene.  del Hygiene.  del Madical Examinar must be notified at event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of I Yes, specify Cu	Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
Maryland 21215-0036	within 72 hours after ene. then "nature!, or ite he Medical Examine	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	(Give	lent's Usual Occu kind of work doni OO NOT use retir	upation e during most of wo ed)	rking	OWN HON	,
and 2		Be	17. Father's Name (First, Middle, Last)  IVAN		KORNEE		18. Mother's Na	me (First, Middle, M	faiden Sumame)	)BTAINABLE
Mary	s 1 and 2 should if Heelth and Menistrem 27 is marked other traumatic	၉	19a. Informant's Name/Relationship (7 ANATOLIY GRABCHE		19b. Mailin	g Address (Stree	et and Number or R	ural Route Number,	City or Town, State	, Zip Code)
a)	Pages 1 and nent of Heelt int: If Item 2: iry or other i		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20b. F	lace of Dispo	sition (Name of patory or other pl	acal		OWINGS M	or Town, State
Balti	permit. Pages Depertment of Important: If It any Injury or once.		21. Signature of Funeral Service Licen			. Name and Add	. 2	OL LEVINS		
,	Physician `		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	n. Do not ente	er the mode of dy	ring, such as cardia	ROAD - P c or respiratory arre	est,	Approximate Interval Between Onset and Death
4	Examiner		Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq			7	) 		
20,	ificate be executed physicien and Cast the burial-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq						
		Medicai	IF FEMALE:	d						
O. Box	at the death certifi by the ettending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 DV6 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	lelivery Day Year
rds, P	The law requires that the te has been signed by th bage 2 should be detache	P	Part II. Other significant conditions or	ontributing to death but not res	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did tob 1 ☐ Ye		to the cause of death?  Probably 4 □Unknown
		Completed						24a. Was ar autopsy perform 1 Yes 2	prior t death	autopsy lindings available o completion of cause of es 2 \( \) No
\ \ \	Physicien: This certificeral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6	Hospital: 1 ☐ Inpatient 2 ☐	FR/Outpatien	1 3□ DOA   O		ath (Check only one dome 5 Sesider		nacifu)
ion of	ding h. After fune	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe ho		Activy
É		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28l. Location (Str City or Town,		Rural Route Number,
	ha Hospital or in 24 hours efte ha Funerel Dir pletely filled in	Medical	29a. Certifier // Certifying Ph (Check only one) 2 Medical Exam	sician: To the bast of my knowiner: On the basis of examina and manner stated.	władga, daath tion and/or inv	senumed at the trestigation, in my	lima data and plans opinion, death occu	and due to the eaurred at the time, da	use(s) and mainer te and place, and d	at stated. ue to the cause(s)
	To the vithin 2. To the complet	Σ	29b. Signature and title of confifier	all		29c. Licer	nse number	29	d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person who d	completed cause of death (Item	1 23a) (Type, I	Print)	55472		10 /11/	06
	Sta	10	31. Date liled (Month, Day, Year)	32. Registrar's Signa	ture	era Au	e/2/1	0,110	21215	
	Registr		OCT 1 6 20		i All	38023				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32588 Amend Item 23a per dr., C860. TO/16/06dhb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 50 p. M >+VZa/dine Utdus /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner times 12 If Under 1 Year If Under 24 Hrs. Loseby 6. Sex 7. Age (In-yrs. last birthday) 8. Date of Birth (Month, Oay Y NOV. 18, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** . 1922 1□M 20 F Months Days Hours Min. Yrs. 83 Director 030-16-7297 Usual Residence of Decedent Pages 1 end 2 should be illed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Ie marked other then "natural", or Items 23s or 28s-f show ury or other traumatic event, the Medical Examinal must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 Ie marked other then "natural", or items 23s or 28s-fehov other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Windsor Mill Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3707 Wildor Ave. 21244 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Midowed 4 □ Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Cashier Liquor Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Patrick Radcliffe Bertha May Scholes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Goad, Daughter-in-Law 3621 Old Milford Mill Road Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Ferenation 3 Removal from State Department of Important: If eny Injury or page 1. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Oct. 12, 06 Baltimore, MD 21. Signatury of Funeral Service Ligensee <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No 1 Tes 2 No After this certifical funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Se. Registrar's Signature Hilling ert 31. Date filed (Month, Day, Year)
OCT 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygier 006 32589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Edmund A. Greaves 10 08 2006 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forest Glen Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1**∑**M 2□F 66 Yrs. Director 579-58-3362 03-05-1940 Jamaica Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ?? is marked other than "natural", or Itame 23a or 28e-f show treumetic event. The Mudical Examinar is ust be natified at DC Washington 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20017 USA 1355 Michigan Avenue NE death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or Itar 1 Never Married 2 Married Specify: Black 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Taxi Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Muriel Allen Edmund H. Greaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 is n any injury or other treun QDCE. Fay Greaves/Wife 3426 Danny Bryan Blvd, Tampa, FL 33619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dovecot Cemetery Unknown St. Catherine, Jamaica 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th St NW, Wash. DC 20011 Approximate Interval Between Onset and Death 23a. Papi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Multiple Priysician Myeloma Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 Tes 2 No 3 Probably 4 Unknown Completed been NEUTROPENIA 24a. Was an autopsy performed?
1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Hospitel or Attending Pt 24 hours after death. Funerel Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/10/06 043121 Chowdley, mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Oay, Year)

OCT 1 6 2006

32. Registrar's Signature

NURUL CHOWDHURY, MD: 15216 DINO DRIVE; BURTONSVILLE, MD20866

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death OCTOBER "14. 2004 Physician 1:50 FM Charles Jacob Horner /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ™** 2 □ F Director 222-10-7845 84 9/8/1922 Delaware Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits I Heelth and Mental Hygiene. Itsm 27 is marked other than "natural", or itsms 23s or 28s-I show other trsumstic sysnt, the Madical Examinar must be notitled at 1 ☐ Yes 2 🛣 No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt 1201 880 Walter Blvd 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: If itsm 27 is marked other than "natural, or itsn any injury or other traumatic avent, the Medical Examinat once. Black, White, etc. 1 XYes 2 No 1942 If Yes, Give Year or Dates: 1947 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Petroleum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ George Horner Coombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capon Bridge Deborah Brauns (Daughter) P.O. Box 531 West Virginia 26711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 10/16 2006 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 23a. Part1. Enter the disease, or count attorn that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) HODGKIN LYMPHOMA Physician /Medical Due to (or as a consequence of) Examiner SECONDARY TO CHEMOTHERAPY PANCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 业 The law requires that the death certificate be executed burial-transit PROLYMPHOCYTIC LEUKEMIA ettending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 💹 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation M 2 ☐ Accident within 24 hours after death To the Funeral Diractor: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dev. Year) 5/06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 M. D., BOON P. LIM, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2006 Registrar

ORIGINAL.

			1 - State of Maryland / Department of Maryland	rtment of Health and M tificate of Death	lental Hygier	2006 32591
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death October 1	3. Time of Death
	/Medi Exami		Lynne R. Hart  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Gilchrist  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore
	Funeral Director		215-34-2410 1 M 2 N F 71 Yrs.	Months Days Hours Min.	Oct. 7, 1	9. Birthplace (State or Foreign Country) Mary Land
	ryland how at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits
	the Ma 28a-f s notified	Director	Md. Baltimore Luthervil	10f. Zip Code	100	1 ☐ Yes 2 👿 No Citizen of What Country?
	leath with the Marylar ns 23a or 28a-f show must be notified at	ral Di	11 Nightengale Way Apt. 6C	21093	Tog. v	USA
ပ္	72 hours after death with the Maryland natural", or items 23a or 28a-f show ileal Examiner must be notified at	Funeral	11. Marital Status  1 Never Married 2 Married  11. Was Decedent Ever in U.S. Armed Forces?  11. Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	"natural", c	ed by	Year or Dates:	☐ Yes 2 🗓 No Specify: ent's Usual Occupation	106	Specify: White
1215	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I once.	Completed	(Specify only highest grade completed) (Give life. D	kind of work done during most of worki O NOT use retired)	ng	Kind of Business/Industry
d 21	ifiled w Hygie other ti ent, th	Be Co	+1 Sale	Sperson 18. Mother's Name	(First, Middle, Maid	Retail  den Surname)
ylan	Mental Merkal arked atic ev	To B	William Ronald Roche	Marjor	ie Starr	,
Mar	d2shcth and thand 17ism			Address (Street and Number or Rura		
	s 1 an of Heal item 2		20a. Method of Disposition 20b. Place of Dispos	Bryan Blvd. Havel		Location - City or Town, State
Baltimore,	t. Pages tment of tant: If it		4□Donation 5□Other (Specify) Hilltop S	ervice Co. 10-17		owson, Md.
Bal	permit. P Departm Importar any Injur		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Ruck Towson Fune: 1050 York Rd. Tow	ral Home,	Inc.
			23a. Part1. Effer the disease or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
	Physician /Medical	П	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Car		Onset and Death
-	Examiner					
	insi.	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury			
90,	ificate be executed a physician and as the burial-transit	I Exa	that initiated events resulting in death) Last  C			
68760,		edical	d			
Box	The law requires that the death certifiate has been signed by the attending oage 2 should be detached for use as	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.0	at the d by the etacher	Phys	9 □ Unknown			
or Vital Records,	w requires that the d been signed by the should be detached	ed by	Part II. Other significant conditions contributing to death but not resulting in the unc	perlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Reco	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ital		Be Co	25. Was case referred to medical	26. Place of Death	performed?  1 Yes 2 (Check only one)	death? No 1 □Yes 2 □ No
or V	> .0.0	ို	examiner? 1 Yes 220No Hospital: 1 Inpatient 2 EP/Outpatient	3 DOA Other: 4 Nursing Hon	ne 5 Residence	6 Other (Specify) hospip
ion	ng ftel	tion:	27. Manner of Death  1 Acident  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury	28c. Injury at Work?  M 1 Yes 2 No	8d. Describe how inj	jury occurred
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	ospital hours a ineral I		29a. Certiffer Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cause	(s) and manner as stated.
	thin 24 the Fu the Fu mplete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.  29b. Sig/Mature and title of certifier	estigation, in my opinion, death occurre		
	Wi No		Marlin	D 58303		Date signed (Month, Day, Year)  DACK 12 2006
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, P. AMAN CAMPLES WY 6565N-Charl	st Barren	na 7	17.04
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	I STUME	9 101) 0	
	Registr	ar	00110500			

State of Maryland / Department of Health and Mental Hygiene 0 32592 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 5:45 PM M October 2006 Walter Harrington Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/10/1916 Birthplace (State or Foreign Country)

DC **Funeral** #**X**M 2□ F 90 577-09-1411 Director Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Takoma Park Montgomery Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7525 Carroll Avenue 20912-USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: WW I 13 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unknown and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Walter Harrington Sr. Elizabeth Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karin Anderson/Other 7007 Woodland Avenue Takoma Park, MD 20912-Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 12 20a Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Beltsville, Maryland 2006 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) MU1358 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancers **Physician** /Medical Examiner ementia leavy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed ng physicien and as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery requires that the death 3 Ectopic pregnancy jo Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2× No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funerel Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the date (s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Groll Ave 31. Date filed (Month, Day, Year) 32. Signature State

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible lak, 157506, Sopies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 12, 2006 Hosseinababi Khadijeh 06:30AM 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

7. Age (In yrs. last birthday) Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 12 11 33 Birthplace (State or Foreign Country) 1□M 💥 F 72 214-47-1657 Vrs Iran Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Woodlawn Baltimore 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Johnnycake 21244 U.S.A. e-Road 6631 - John 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Asian 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

[] n 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unknowh Elementary/Secondary (0-12) 12th grade Unknown College (1-4or 5+) 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 6631 Johnnycake Road, Baltimore, Md Farooq Marfani-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 10/13/06 Randallstown, 21. Signature of Funeral Service Licensee Markand Address of active 21215 ree 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). PNEUMONIA Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2**X**No 3 Probably 1 Tes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 20 1 Tes 25. Was case referred to medical examiner?

Priysician /Medical Examiner

burial-transit

use as the

and

Department of Important: If any injury or once.

**Physician** 

/Medical

10a State

Director

Be Completed by Funeral

MD

Examiner

**Funeral** 

Director

item 27 le marked other than "natural", or Iteme 23a or 28a-1 ehov other traumatic event, the Michigal Examphar must be notified at

Pages 1 end 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. Int: If item 27 le merked other than "natural", or Iteme 23.

Hygiene.

Baltimore, Maryland 21215-0036

with the Maryland

Examiner Completed by Physician/Medical Be Certification: To

or Attending Physician: The law requires that the death certificate be executed

certificete

within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,

within 24 hours a

To the

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

27. Manner of Death
1 XNatural
2 ☐ Accident

3 Suicide

29a, Certifier

Medical

State

Registrar

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

26. Place of Death | Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

2 ER/Outpatient

28b. Time of

Injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TOWSON, MARYLAND 21204

29b. Signature and title of certifier

29c. License number D17695

29d. Date signed (Month, Dav. Year)

October 12,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

ABDALLAH J HELOU.

5 Pending investigation

6 Could not be

7601 32. Registrar's Signature

M.D.

31. Date filed (Month, Day, Year) OCT 1 6 2006 OSLER DRIVE

			1 - For State Registrar	State of Ma	arylar	nd / Depa		t of H	eaith a		-		006	32594
	Physici	an	Decedent's Name (First, Middle, Last	st)							2. Date of Do Month	Day	Year	3. Time of Death
	/Medic	cal	Emma	J.				andy			10			11:15a <sup>™</sup>
	Examir	er	4a. Facility Name (If not institution, given Future Care Nu		me				Location of			4c. Co	Day Year O4 2006 11:1  4c. County of Death  ear) 9. Birthplace (State or Country) MD  10d. Inside City 1 Ares  14. Race - American Indian, Black, White, etc.  Specify: Black b. Kind of Business/Industry  Private  Iden Surname)  Iffy or Town, State, Zip Code) 212  2B, Balto, Mo c. Location - City or Town, State  Cambridge, Md  Ore, Md 21215  Approximate Interval Betwoonset and Day  Month Day Ye  23d. Date of delivery Month Day  24b. Were autopsy findings averaged and Day  27 No 10 Yes 2 No  11 Yes 2 No  12 No 14 Number or Rural Route Number of Business Property Number or Rural Route Number of Rural R	
	Funeral		Social Security Number     6. S	ex 7. Ag		last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9. Birtho	place (State or Foreign
	Director		218-05-4703	□M 2[X]F	88	Yrs.	Months	Days	Hours	Min.	12 2	$\overset{^{\mathrm{a}}}{4}\overset{^{\mathrm{Y}}}{}\overset{^{\mathrm{a}}}{1}$ 7	Cour	MD
	and *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation							Od Incide City Limite
	Maryli f eho	ō	MD NA			altim							'	1 Xes 2 No
	r 28e	rec	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cour	ntry?
	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other then "natural", or items 23s or 28e-f ehow imatic event, the Medical Evantian must be routified at	Funeral Director	1027 Cathedral	Street	4B			212	201			U	.S.A.	
	teme trim	uner	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe i, Puerto F	cify Yes or Ne Rican, etc.)	0- 14.		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 200 ! If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:		,	1	anifu.	
9	2 hours	ed	15. Decedent's Ed	ucation		16a. Deced	dent's Usua	al Occupa	ition			16b Kind		
215	thin 7.	piet	(Specify only highest gra	de completed) College (1-4or 5	i+)	(Give	kind of wor DO NOT us	rk done d se retired,	luring most )	of workin	ng			203(1)
2	filed wil Hygien other th	Completed	8th grade	na		Doi	mest:	ic						
and	be fill be fill be did	Be	17. Father's Name (First, Middle, Last) William Wilson									, <i>Maiden S</i> u	mame)	
7	should be and Mental le marked o	은	19a. Informant's Name/Relationship (7	voe Print)		10h Mailin	a Addrose		Emma			or City or T	Chata 7'	0-1-1
Σ	of 2 s		Eli Day-Son	<b>ypo</b> ,										
Je,	s 1 av		20a. Method of Disposition		20Ь. F	Place of Dispo cemetery, cren					ate	•		
Ë	Page nent c ant: if ury or		1√Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Smith				0/14	4/06	Cam	bridge	e, Md
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 ie marked any injury or other treumatic ex		21. Signature of Funeral Service Licen	see	/	M.22	. Name an arch	d Addres	s of Facility	ξt.				
	₫ Ω <u>5</u> € 6		John V.	and		4.	300 1	Waba	ish A	ve,	Balt		, Md	21215
	Pnysician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each lir	the deat	h. Do not enti							=	Approximate Interval Between Onset and Death MONTHS
8760,	Attending Physician: The law requires that the death certificate be executed X in death.  The death.  Settor: Alter this certificate has been signed by the attending physician and in the funeral director, page 2 should be detached for use as the burial-transit in the funeral director.	lical Examiner	Faquer tistly liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  c.  Due to (or as  d.	a conseq	E (C) S ( uence of):	LER	lotic	- Can	LD to V.	AJCULA	L DIF	03E	YEARS
Division of Vital Records, P.O. Box 6	he death certific r the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pre Other (spe					23d.		,
٣.	that the ded by detail	Ph	Part II. Other significant conditions co	ntributing to death be	ut not resi	ulting in the un	nderlying ca	ause givei	n in Part I.		23e. Did t	obacco use	contribute to th	e cause of death?
rds	quires n sign	ed by	CHRONIL	OBSTA	2001	VE P	IL MOR	YARY	DUSE	ASE	10	Yes 2□N	o 3 Prob	ably 4 Unknown
000	aw re	Completed	METASTA		_	AST		/			24a. Was		4b. Were autor	osy findings available
m m	The ate he	E O									autor perfo	osy ormed? 2 No	death?	_
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?							of Death	Check only			
<del>_</del>	Physi this c al dire	5	ILI 185 ZUNO	Hospital: 1 Inpatie		ER/Outpatient			4 Nur					)
- Lo	ding h.	tion	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? es 2∐N		8d. Describe I	how injury oc	curred	
/ISI	el or Attending Phy s after death. Il Director: After this d in by the funeral d	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ırv - At ho	ome, farm, stre					8f Location /	Street and N	umher or Rura	Route Number
ă	To the Hospitel or A within 24 hours after To the Funeral Dire or mpletely filled in bi	Il Certification;	4   Nomicide	building, etc	. (Specify	<i>(</i> )					City or Tov	wn, State)		
	P Hos	edical	(Check only one)	ner: On the basis of and manner sta	examina	meage, death tion and/or inv	estigation,	in my opi	nion, death	place, an	d at the time,	date and pla	manner as sta ce, and due to	the cause(s)
	vithir To th	M	29b. Signature and title of certifier	4.			29c.	License	number				-	-m/
i			1 /3 Vas	anthale	ev	nox		DI	125	10		OCTO	BER 1	9 2006
	3		30. Name and address of person who c			23a) (Type, F	Print)	Eu	7AWS				_	
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 1 6 2006	32. Registra	r's Signa	ture	120							

	*		1 - State Registrar  1. Decedent's Name (First, Middle, Last	State of Maryland 26 per verb.,G	O <del>e</del> rar.	icale ort		2. Date of Deat		3. Time of Death
	Physici		Jamie		1	lunter		October	Day Yes	ar
,	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	46	. City, Town, or	Location of Dea	ıth	4c. County of D	
			The Johns Hope	kins Hospital			more ci			
	Funeral Director		5. Social Security Number  6. Se  483-80-6386  Usual Residence of Decedent	7. Age (In yrs. las		Under 1 Year onths Days	If Under 24 Hr Hours Min	. (Month, Day,	Year) 9.1 3 1958	Birthplace (State or Foreign Country)
	low		10a. State 10b. County	10c. City, 1	Town or Location	on				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	tor	MD Washin	naton	Ba	onsbox	0			1 PYes 2 □ No
	or 28	Oire	10e. Street and Number	0,		Of. Zip Code		1	0g. Citizen of What	Country?
	ath w	rail	28 S. Main S			a1			US	
	itami	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was	Decedent of Hi s, specify Cuba	ispanic Origin? ( In, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
35	urs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 200	Specify:		Specify:	white
Ş	72 hours after natural', or ita dical Examina	Completed	15. Decedent's Edu (Specify only highest grad	ication 1	16a. Decedent	's Usual Occupa	ation	odina	16b. Kind of Busine	
Maryland 21215-0036	within 7 iene. then "c	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO l	NOT use retired,	du <i>ring</i> most of w )	DIKING	C \	
2	Hygier Hygier ther th		1 a		Ca	shier			Salv	25
anc	ntal Hed of	To Be	17. Father's Name (First, Middle, Last)	41.15				ame (First, Middle, I	174	i>
ڇَ	should nd Men marke	٢	19a. Informant's Name/Relationship (T	old+	19b Mailing A	ddress /Street a	KU+1	Rura / Route Number	City or Town State	
	nd 2 still ar ar 27 is		David Hunter	husband	2049/	-	merson	-	_	ntanyMD
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any righty or other traumatic event, the Medical Examples must be notified at ance.		20a. Method of Disposition	20b. Plac	e of Dispositio				20c. Location - City	
Ē	Page nent c int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	removal from State	etro (	romoto		-11-06	Balton	MD
Baltimore,	Departr Departr Importa any njt		21. Signature Junera Service Licens			ime and Addres	The state of the s		,	
D	20 E 2 9		1 Jewel	I hanch	IIA	W193	a Midva	Mer Dr. Z	Jessup, PY	7 18434
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death. In cause on each line.  Fulminan				ac or respiratory arre	est,	Approximate Interval Between Onset and Death Sdays
	/Medical		resulting in death)	Due to (or as a consequer	nce of):					
	Examiner		Sequentially list conditions.	. Narcotic an		tamin	ophen	intoxica	ation	6 days
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):			//		
	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequen	nce of):		$\alpha$	/ WI	XAMINER	
8/60,	sate be executed obysicien and the burial-transit		(	d			1/ /	MEDICAL		_
Q	death certificate be executed e attending physicien and od for use as the burial-transit	Physician/Medical				ad a	SCATION AT	ROVED OF MEDICAL E		
BOX 6	th cer tendir r use	an/N	230. Has decedent program	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		opic pregnancy	7	~		•
	that the death certific ed by the attending pl detached for use as t	sici	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	4☐Pregnant at time of death		ner (specify)			Month	Day Year
л Э	hat th d by i	Phy	Part II. Other significant conditions co	atchuting to death but not reculting	ng in the under	hina asusa au	no in Port I	23a Did tob	anno uno contributo	to the cause of death?
Division of Vital Records,	Attending Physician: The law requires that the rdasht. After this certificate has been signed by the by the funeral director, page 2 should be detache	d by	Tarrit official offic	minouting to document not resulting	ng in the under	lyilig cause give	arrant.	1 □ Ye	N/	Probably 4 Dunknown
Ö	w requ	Completed						24a. Was a		autopsy findings available
Ď Ľ	he la e has age 2	m d						autops perform	y prior t ned? death	o completion of cause of ?
20	an: T tificat tor, pa	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2	No 1□Y	es 2 No
<u> </u>	lysici lis cer direc	ToB	examiner? 1 No 2 No	lospital: 1 Inpatient 2 ER	VOutpatient 3	DOA Othe	AC.	Home 5 ☐ Reside		pecify)
0	ng Ph fter th neral	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury	28c. Injury Work			w injury occurred	
<u> </u>	eath. or: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be	September 26,2006 U	nknown PM		res 2 No			ophen ingerted
$\leq$	or At ifter d Direct in by	E E	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		factory, office		City or Town	, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	Home	curred at the time	no data and also			Boansbore MD
	24 h 24 h Fur etely	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	and/or investi	gation, in my op	pinion, death occ	curred at the time, da	ate and place, and d	ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number	25	9d. Date signed (Mo	onth, Day, Year)
	( )		Ibironke Odi	14860, Medical D	Soctor	Res-	000		October 6	,2006
	(10)		30. Name and address of person who co	ompleted cause of death (Item 23	Ba) (Type, Print					
	10		Ibironke Oduyebi	ompleted cause of death (Item 23)	ans Hosp	ital, 60	O North i	Noife Street	Bultimore	, Maryland 21287
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	DARLY					

			1 - For State Registrar	State of Mai		artment of H			iene g. No. 2 0 (	6	32596
2.	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
10.00	/Media		Nels Folke Kans					10	03 2006		5:10 p <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give s 15107 Interlachen	Dr.#510		4b. City, Town, or Silver S	Spring		4c. County o		у
	Funeral Director		343 20 3701	7. Age	79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birthp Coun [11i	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Many 8-1 sh	ctor	MD Montgome	ry	Silver Sp	ring					MXYes 2 □ No
	h with the	ai Direc	10e. Street and Number 15107 Interlachen	Dr. #510		10f. Zip Code 20910			0g. Citizen of Wh USA	nat Coun	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itama 23e or 28e-f show shy injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married ANArried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2825No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race Black Specify:	- Americ White, whi	etc.
215-0	thin 72 ho e. en "natur Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	orking	16b. Kind of Bus	iness/Inc	dustry
2	ed wit ygiene ygiene yer tha	Соп		3		neer			Telecom		
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, i	Maiden Sumame	)	
Ž	12 should be and Mental 7 is marked of raumatic ever	2	Nels Folke Kans  19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ng Address (Street a		e Ekwall	. City or Town. S	tate. Zio	Code)
Ž	alth a		Nina K. Kans/wife			Interlac			-		
Baltimore, Maryland 21215-0036	Pages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crea Chesapea	osition (Name of matory or other place ike Cremat	ory 10-		20c.Location - C		
Balti	permit. Departn imports sny inju		21. Signature of Funeral Service License	me no	135 8 22 Ra	2. Name and Addres	ss of Facility a1 & Crei	Silv mation Sv	er <sub>3</sub> Sprir	lg,M	D ve.20910
}	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Lung Can		ter the mode of dying	g, such as cardia	c or respiratory arr	est,	]	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate		consequence of):						
8760,	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
.O. Box 68	The law requires thet the death certifica tle has been signed by the attending ph tage 2 should be delached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti		ry Day Year
<u>α</u>	quires thet n signed b uld be deta	d by Pl	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.				e cause of death?
l Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autops perforr	y pri ned? de	ere autop or to con ath? ] Yes	osy findings available npletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	an aitale		Tou.		ath (Check only on	θ)		
Division of \	ding Phys .r After this funeral di	tion: To	1 Yes \$\frac{1}{2}\text{No} \\  27. Manner of Death  1XX\text{Natural} 5 \text{ Pending}  2 \text{ Accident} investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day )		f 28c. Injury Work	4 🗆 Hursing I	Home 5 X Reside 28d. Describe ho			')
Divisi	sai or Atteness after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	reet, factory, office		28f. Location (St City or Town		or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examir	sician: To the best of ter: On the basis of e and manner state	xamination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occi	e, and due to the ca urred at the time, da	tuse(s) and mannate and place, an	ner as sta d due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	670	xlein	29c. License MD22	. 7	2	od. Date signed (	Month, E	Day, Year)
	10		30. Name and address of person who co	/					1	1	
	Sta	to."	Shakun Malik MD  31. Date filed (Month, Day, Year)	3800 Réser		washingto	n DC 200	)16			
	Registr	-	OCT 1 6 200		. H. A.	sell)					

		State of Maryland / Departm	nent of Health and Mocate of Death	fental Hygie	ne	32597	
Physic /Medi		1. Decedent's Name (First, Middle, Last) Charles Thomas Kocsey			Day Year	Time of Death	
Exami Funeral	ner	Mercy Manical Canter 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	City, Town, or Location of Death  Lime Re  Inder 1 Year   If Under 24 Hrs.  Inths   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	ar) Country)	Cdy State or Foreign	
Director work and and and and and and and and and and		214-02-3195   WOM 2DF   35 Yrs.   Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Baltimore City   Baltimore		04/08/	10d. In	side City Limits	
death with the Maryland ms 23e or 28e-1 show Livelibe nutified at	i Director	_	f. Zip Code 21202		Citizen of What Country?	it Country?	
in in in in in in in in in in in in in i	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes,	Decedent of Hispanic Origin? (Spispecify Cuban, Mexican, Puerto as 28 No Specify:		14. Race - American Inc Black, White, etc. Specify: White	nite, etc.	
within 72 ene.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Education (Give kind of life. DO NO life. DO NO Waiter	Usual Occupation of work done during most of work OT use retired)	ing 16b	Kind of Business/Industry	•	
aryland 2 should be filed and Mental Hygi merked other umatic avant, ii	To Be C	17. Father's Name (First, Middle, Last)  Floyd Mayes  19a. informant's Name/Relationship (Type, Print)  19b. Mailing Add		e (First, Middle, Maid Catherine K al Route Number, Cit	ersey	1	
Magazia 27 is		Mark R. Dutton/Friend 922 St  20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State  20b. Place of Disposition cametery, crematory	ubblefield Lane (Name of or other place)	Baltimore Date 20c. Oct 12		tate	
Baltimore, permit. Pages 1 e Department of Hee important: If itsm any injury or othe		21. Signature of Funeral Service Licensee 22. Nam Cre	Crematory Inc.  The and Address of Facility  The and Funera  The Green Pastures	al Alternat	ives	_	
Physician / Medical Examiner per per per per per per per per per p	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Kaposi Saca	coma	Inten	oximate value of the control of the	
, F.C. BOX 68 thet the death certificat red by the ettending phy detached for use as th	Physician/Med		ic pregnancy r (specify)		23d. Date of delivery Month Day	Year	
HECOTAS, P. The law requires thet: ate hes been signed by page 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.		o use contribute to the cau 2 No 3 Probably	se of death?	
	e Completed	Of Was and related to a day		24a. Was an autopsy performed 1 Yes 2 5	24b. Were autopsy fin prior to completic death?	on of cause of	
ng Phys ng Phys Mer this Ineral di	Certification: To Be	27. Manner of Death  1 Salurial 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.	28c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe how in 28f. Location (Street	and Number or Rural Rout	ə Num <i>b</i> ər,	
DIVISIO  To the Hospitel or Attendi within 24 hours after death.  To the Funeral Director: A  completely filled in by the it.	ledical Cert	29a. Certifier  (Check only  2   Medical Examiner: On the basis of examination and/or investigations)	red at the time, date and place ition, in my opinion, death occurr	City or Town, Shared at the time, date a	(a) and manner as state 4	ause(s)	
To the To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Y	(ear)	
St. Regist	_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Slook 701 V. Pratt St. Baltimore  31. Date filed (Month, Day, Year)  OCT 1 6 2006  32. Registrar's Signature		DI HD' Brt	ot of Psychiet	rey, 4th	

		•	For State Registrar	State of Ma	ryland / Dep	oartment o			ınd M		iene g. No	006	325	98
	Physicia		Decedent's Name (First, Middle, Last)     ILYA		KAL	.IKA				2. Date of Deat Month OCTOBER	-	2006	3. Time of 0	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	wn, or L	ocation o	f Death	4c. County of D				
			JEWISH CONVALESCE						BALTIM				-	
1	Funeral Director		5. Social Security Number 6. Sex 1 🕅	M 2□ F 7. Age	78 Yrs.	Months D	Days	If Under 2 Hours	Min.	8. Date of Birth 2001th Day 12/25/1	927	9. Birth Cou	OKRAIN	Foreign
	pue		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside City	y Limits
	Maryla f sho	tor	MD N/A		BALTIM	ORE							1 Yes	2 □ No
	ath with the Marylar 23a or 28a-f ahow	irec	10e. Street and Number			10f. Zip Co				1	-	of What Cou	ntry?	
	23a c	rai D	3021 FALLSTAFF ROAD			2120						.S.A.		
0	hours after death with the Maryland lural', or items 23s or 28s-f show al Examinar must be notified at	Funerai Director	11. Marital Status 1 □ Never Married 2 ☑ Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		If Yes, specify	Cuban	, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Ameri Black, White	etc.	
2-0036	ural', c	d by	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes 21X		Specify:				ecify:	WHITE	
ה ה	within 72 h 8ne. than "natu ne Medica	iete	15. Decedent's Educ (Specify only highest grade	completed)	(Gi	cedent's Usual ( ve kind of work of . DO NOT use	done du	uring most	of worki		16b. Kind	of Business/li	ndustry	
7 7	d withing the state of the stat	Completed	Elementary/Secondary (0-12)	College (1-4or 5		IVER_					I	RANSPO	RTATION	<b>I</b>
מפי	al Hyg d othe	Bec	17. Father's Name (First, Middle, Last)		14.51	71/5				(First, Middle, I			TALED! E	
yland	ould to	户	ISAK			_IKA	74		IDA	/ Courte Aliambas		UNOBTA		
Ma	d 2 sh th and th and 7 is rr traurr		19a. Informant's Name/Relationship (Type YEVGENIA KALIKA /	WIFE						I Route Number				200
ē,	f Healt f Healt item 2		20a. Method of Disposition		20b. Place of Dis		of					ion - City or T		.03
Ê	nit. Pages vartment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	BALTIMORI				0/13	/2006 1	REIST	ERSTOW	N, MD	
Baitimore,	permit. Departrimports any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE,										208	
Ü			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not e								Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	(	Lymph	ama							Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a									0	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):									
	ansit	Examiner	that initiated events											
Ď	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	a consequence of):									
68/60	9 % 9	dicai	<b>L</b> d	l										
	eath certific ettending pl	√/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							23d	. Date of delik	ery	
O. Box	The law requires that the death certifica ate hes been signed by the ettending phrage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown		3 □Ectopic preg 5 □ Other <i>(spec</i>						Month	Day Y	'ear
ב	that the ed by detacl	/ Ph)	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cau	se giver	n in Part I.		23e. Did tol	pacco use	contribute to	the cause of de	eath?
rds,	quires tha n signed ald be del	d by								1 🗆 Ye	s 2 🔿	3 ☐ Pro	bably 4 □U	nknown
Vital Records,	law requir ss been si 2 should i	Completed								24a. Was a	n 2	4b. Were aut	opsy findings a	available ause of
ř		Com								perfor 1 ☐ Yes	ned? 2.200	death? 1 ☐ Yes	2 No	
Vıta	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe	- \ /		(Check only on		704 (0		
Ö	ding Physician: After this certific funeral director.	n: To	27. Manner of Death	28a. Date of Injur	nt 2 ER/Outpat		: Injury Work			me 5 Reside 28d. Describe ho			ny)	
<u>ö</u>	Attending or death. actor: Attending by the fune	atio	1  Accident 5  Pending investigation	(Month, Day	(Year) Injur	м		es 2 □ I	No					
DIVISION	or Atter de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	iry · At home, farm, c. (Specify)	street, factory, o	office			28f. Location (Si City or Town	treet and N n, State)	lumber or Rui	al Route Numb	)9 <i>r</i> ,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi		29a. Certifier 12 Certifying Phys	ner: On the basis of	examination and/or									)
	o the lithin 2.	Medicai	29b. Signature and title of certifier	and manner sta	ted.	29c. t	License	number		2	9d. Date s	igned (Month	Day, Year)	
	⊢≯⊬ö		> July fl	~ M		Ī	12	203	9					
	3		30. Name and address of person who co	30171 0	40 28	e, Print) Su	ith	- Ac	م مد	Busit	276	212	09	
4.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	perces								

			For State State Registrar	ate of Maryland	/ Depa	artment of H tificate of I	lealth and M <i>Death</i>	ental Hygi	en2006	32599
	Dhuaini		Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio	al	Thomas Kennerly						04 2006	19:03 M
	Examir	er	4a. Facility Name (If not institution, give street  Southern Maryland H			Clinto	Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	"	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign
	Director		248-22-6619 Usual Residence of Decedent	83	Yrs.			12-17-1	922 Ora	ngéburg, SC
	ryland		10a. State 10b. County		Town or Lo					10d. Inside City Limits
	he Ma 28a-1 s	Director	MD Prince Geor	ge's Uxor	Hill			1 40	025	1 ☐ Yes <b>X</b> No
	3a or	i Dir	5507 Chloe Drive			10f. Zip Code <b>2074</b>	5	10	g. Citizen of What C <b>USA</b>	ountry?
36	be filed within 72 hours after death with the Maryland nat Hygiene. sd othar than "natural", or Itama 23a or 28a-f ahow avent, the Medical Examinar must be notified at	by Funerai	11. Marital Status 12. W Ar 1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? YYes 2 \sumbox No res, Give aar or Dates:	l l		ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
21215-0036	ithin 72 hou le. nan "natura n Medical E	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) bllege (1-4or 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of working	09	6b. Kind of Business	s/Industry
	filed w Hygien other th	Co	12 17. Father's Name (First, Middle, Last)		Pape	r Cutter	18. Mother's Name			f Commerce
aŭ	should be to and Mental I marked of umatic ave	To Be	Thomas Kennerly				Alice G		alden Sumame)	
Maryland	2 shou and N is mar sumat		19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailin	g Address (Street	and Number or Rura	Route Number,	City or Town, State,	Zip Code)
	1 and Health mm 27 ther tr	1	Allyce B. Kennerly  20a. Method of Disposition	20b. Pla		Chloe D	rive, Oxo		MD 20745 0c. Location - City o	r Town State
mor	Peges ent of lant; If Its		1 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	al from State cen	netery, cren	natory or other place	Θ)		rentwood,	
Baltimore,	permit Peges 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic an <u>once</u> :		21. Signature of Funeral Service Licensee	1 00	22	. Name and Addres			uneral Ho	
	40240		23a. Part . Enter the disease, or complication chock, or heart failure. List only one cau	s that a used the dealm.	Do 🔊 ent.	he mode of dvin			NW, Wash.	Approximate
Z	Physician		Mock, or heart failure. List only one cau Immediate Cause (Final disease or condition	e pyeach line.	101		you			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Die to (or as a conseque	nce of):	Jours	y we	ANGE	muy	
	S S	e.	Sequentially list conditions, b	Due to for as a consulue	nce of:					
	cuted or ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c							
60,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
68760,		edicai	d							
P.O. Box	The law requires that the death certific are has been signed by the ettending page 2 should be detached for use as	Physician/M	in the past 12 months?	ves, outcome of pregnand □Live birth 2 □ Fetal d □Pregnant at time of dea □Unknown	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	w requires the been signed t should be det	þ	Part II. Other significant conditions contributi	ng to death but not result	ing in the ur	iderlying cause give	en in Part I.			o the cause of death?
al Records,	Phyaician: The law r this certificete has be ral director, page 2 sh	Completed						24a. Was an autopsy performe 1 Yes 2	ed?   death?	utopsy findings available completion of cause of s 2 \( \square\$ No
Division of Vital	aician s certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ıl: 1 ☐ Inpatient 2 EF	VOutpatien	t 3□ DOA Othe	26. Place of Death		ce 6 ☐Other (Spe	
n of	ding Phy h. After this funeral c	on: To			8b. Time of Injury	28c. Injun		8d. Describe how		eciry)
Sio	teath. tor: Af the tu	catic	2 Accident investigation			M 1 []	Yes 2 □No			
<u>&gt;</u>	el or Attend s after death il Director: , id in by the f	Certification;	4 Homicide determined 286	<ul> <li>Place of Injury - At hom building, etc. (Specify)</li> </ul>	e, farm, stre	eet, factory, office	2	81. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
	To the Hospitet or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  1	To the best of my knowled in the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	0/1		29c. License	Tumber	290	d. Date signed (Mon	th, Day, Year)
	0		30. Name and didress of person who come et	ad the of death flow?	39)	Print)	1583	84	10-4-	06
	5		William Carter 7.				MD 20735			
	Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) 0 (7 1 6 2006 //	32. Registrar's Signatur						

06-07558 Francis M. Litz Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	te or iviaryianu	•	ificate of		nu ment	, ,	eg. No. 2 (	006	32601
Physi Medical Exa								2. Date of Dea Month		r	ime of Death
ivieuicai Exa	mile	Francis M.  4a. Facility Name (if not institution,	Litz			lb. City, Town,	or Location of	Month October 7	, 2006 4c. County o		0000 hrs
		2600 blk Miles Avenue	give etreet and namber)			Baltimore	or Eocation of	Beaut	40. Oddiny c	Death	
Funer		5. Social Security Number 6	5. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Ye			th(MM/DD/YYYY		ce (State or
Directo	or	265-77-1751 Usual Residence of Decedent	1 X M 2 F	36	Yrs.	Months Da	ays Hours	Min. APR 3	1970	Foreign Country	) MD
/ any		10a. State 10b. County		10c. City, T	own or Locati	on				100	Inside City Limits
and <b>show</b>	j   5	WV Marior	ı	Fa	irmont					1	Yes 2 X No
Магу	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?	
ith the	a la		12. Was Decedent	Ever in II C	12 10/0	265		m2 / Cman f : Was as No	USA		Latina Diani
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any	Funeral	1 X Never Married 2 Mar	ried Armed Forces?		If Y	es, <b>sp</b> ecify Cub	an, Mexican, I	n? ( Specify Yes or No Puerto Rican, etc.)	- 14. Race White		ndian, Black,
s after	<u> </u>	3 VVIdowed 4 Divor	ced If Yes, Give Year or Dates:	anloted) 1		Yes 2 X N		is all of months along	Specify:	white	
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or			st of working li		ind of work done use retired)	16b. Kind of Bus	siness/Indus	try
036 thin 7 ne	du	12			Constr	uction	Worker		Const	ructi	on
5-0( lled wi Hygier of ther	S	17. Father's Name (First, Middle, L	ast)					Name (First, Middle, i			011
21215-0036 wild be filed within 7 Mental Hygiene marked other than	Be	Francis Michae  19a. Informant's Name/Relationshi		•	10h Mailina	Address (O)	Lind	la Flashr per or Rural Route Nur		A	
L shou r and N	2	Linda Litz - n			1			Fairmont,			Code)
e, N   and     Health		20a. Method of Disposition	-		ace of Disposi	tion (Name of c	emetery,	Date	20c. Location -	City or Town	n, State
MOF Pages ent of int: If	l othe	1 Burial 2 X Cremation 4 Donation 5 Other Spe		ale.	,		tory	10/14/2006	   Belts	sville	MD
Baltimore, MD oernit. Pages I and 2 sho Oepartment of Health and important: If item 27 is	2	21. Signature of Funeral Service Li		1100	22. N	ame and Addre	ss of Facility	D. Lohrma	nn PA	771110	, 110
		23a. Part I. Enter the disease, or or		M0098	6	8717 Gr	een Pa	stures Dri	ve, Tows	son, MD	21286
Physicia /Medic		failure. List only one cause of	n each line.						est, snock, or nea		pproximate Interval etween Onset and Death
Examin	er	Immediate Cause (Final disease or condition resulting in death)	a. Narcotic (		and coo	caine int	oxicatio	on			Death
	١.	Sequentially list conditions,	b								
	je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
/ 9	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
760, icate be executed physician and	ical is	X UNPENDED	d.	11.	37 30		000.00	V. 4.V			
760, icate be	Medical	IF FEMALE:	23c. If yes, outcor			,perML,g	860,10/2	20/06 11	23d. Date of	delivery	
Ox 687 sath certific	ror use as r	past 12 months?	1 Live birth 4 Pregnant at	time of deat	h =		Ectopic	pregnancy	Month	Day	Year
Box le death the atte		1 Yes 2 No 9 Unkn			tn 5 Oth	ner (Specify)					_
Division of Vital Records, P.O. Box 68' rate of attending Physician: The law requires that the death certificate has been signed by the attending	by Phys	Part II. Other significant condition	ns contributing to deat	n but not res	sulting in the u	nderlying cause	given in Part		bacco use contrib	_	
Division of Vital Records, P.C pital or Attending Physician: The law requires that ours after death erral Director: After this certificate has been signed	ed t			<u></u>				_	3 2 No 3		
Corclaw rechas be	Completed							24a. Was autop	sy pi		findings available etion of cause of
Re( The ficate	္မီ ၂	25.00						1 ✓ Yes		<b>✓</b> Yes	2 No
<b>'ital</b> sician:	B B	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 F	R/Outpatient		Othor:	Nursing Home 5	Residence 6	Other See	
of V g Phy fter th	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Iniu	ırv I 2	28b. Time of Ir		jury at Work?		how injury occurre		
On endin sath or: A	tio I	1 Natural 5 Pendir		. 1	Fnd 10:0	n am ¹□	Yes 2	No unknown			
VISI or Att or Att Orect	Certification:	2 Accident Investi 3 Suicide 6 CY Could	not be 28e. Place of Ir				building, etc.	. 28f. Location (	Street and Numbe	r or Rural R	oute Number, City
Spital hours a		4 Homicide  29a. Certifier 4 Certifying Physics	ined (Specify)	found	l in park	ted van		Baltimor	e, M600 bl	K. TILLE	s ave.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and	Medical	(Check only Certifying Fify	sician: To the best of m iner: On the basis of exa and manner stated								use(s)
F 3 F	∯ <b>§</b>	29b. Signature and title of certifier	1 1				nse number	· · · · · · · · · · · · · · · · · · ·	29d. Date signe	d (Month, D	Day, Year)
X.	1	4,	W. 1/			0.0	C.M.E.		October 8, 2	2006	
41		30. Name and address of pe son way	no completed Juse of c ty Chief Medical E	,	,	n Street, Ba	altimore M	1D 21201			
77	State		68								
Reg	istra	1.11.1 10.	7000	Alland As	To ASSE	P. A. Conner					

State of Maryland / Department of Health and Mental Hygienes 32601 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Charles Henry Mancha 6:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2935 Main St. Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 3, 1917 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 89 Yrs 212-18-3093 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or itema 23a or 28a-f show the Wedical Examiner must be notified at 1 Yes 2 No Maryland Directo Carroll Manchester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2935 Main St. 21102 U.S.A. filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Owner, Operator Sawmill permit. Pages 1 and 2 should be filed v
Department of Heelih and Mental Hygie.
Important: If Item 27 is marked other tt
eny injury or other traumatic event, this 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Albert Henry Mancha Martha Kate Baumgardner 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Mancha - wife 2935 Main St., Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Davids Cem. Oct. 16,2006 Hanover, Pa. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility. Eckhardt Funeral Chapel P.A. 3296 Charmil Dr., Manchester, Hall Elledo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ♣No cete has been signification of page 2 should b 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete has 1☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After s after dea... 1 ANatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Z Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0018200 700-A pade Rd war minda m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACIANNA. CHITRACHEDY N

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 6

**ORIGINAL** 

32 Registrar's Signature

MATTHEWS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

4e. Facility Name (If not institution, give street and number)

ROOSEVELT

OUENTIN

**Physician** 

/Medical

Examiner

14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Sumame) OUEENIE ELIZA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 20c. Location - City or Town, State BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 ₩6 26. Place of Death (Check only one) Other: 4 Thursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) D00 614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARTIMOKE MO LIBERTY HUTS Mic. 21215

Reg. No 2006

4c. County of Death

USA

1:31PM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 XYes 2 No

Month Day 15, Year OCTOBER 15, 2006 Day

2. Date of Death

State Registrar 2950

AF LOSO OK

31. Date filed (Month, Day, Year)

2600

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible.
AMEND TTEM/8, periff, Cool, 11/7/06, WS
State of Maryland / Department of Health and Mental Hygiene 106

			1 - For State Registrar		Oldic 0	i iviai yiai	(	Certifica	ate of	Death	Wernarry	Reg. No.	6 32603	
	-		1. Decedent's Nam	ne (First, Middle, La	ist)						2. Date of De	eath	3. Time of Death	
	Physici /Medio		Virginia	a L. Moor	re						10	11 20		
	Examir		4a. Facility Name (	'If not institution, giv		. 1 - 1		4b. C	ity, Town,	or Location of Dea	ath ,	4c. County of I		
			5. Social Security	11 / 59 1	NOT P	7. Age (In yrs.	last hirth	dough If LID	der 1 Year	edal E	S R Date of Bi		Birthplace (State or Foreign	_
	Funeral Director		214-50-	2357	1□ M 2(XF	. Age (III yrs.	57 Y	Monti				rth <b>1949</b> 9.	Country) Aryland	
	and and		Usual Residence o 10a. State	10b. County		10c. Ci	ity, Town	or Location					10d. Inside City Limits	
	Maryl	ţ	MD	Baltim	ore	No	ttin	gham					1 ☐ Yes 2 🗷 No	
	ith the Marylar or 28a-f ehow	rec	10e. Street and Nu	ımber				10f.	Zip Code			10g. Citizen of Wha	t Country?	
	th with	aiD	18 Stewa	arton Cou	rt			2	1236			United St	tates	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Mudical Examinal trainst ke notified at Once.	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2⊡ Married 4 ∰Divorced	12. Was Deci Armed Fo 1  Yes If Yes, Gin Year or D	edent Ever in U prces? 2  No ve vates:	J.S.		ecedent of I specify Cub s 2 No		Specify Yes or Norto Rican, etc.)	14. Race - / Black, \	American Indian, White, etc. K	
_ < O	72 ho	ted	(Spec	15. Decedent's E	ducation		16a. D	ecedent's U	Isual Occup	pation	orkina	16b. Kind of Busin	ess/Industry	-
2121	y within jiene.	Be Completed	Elementary/Seco		College (2	1-4or 5+)		ntract		during most of w	orking	State Go	vernment	
, - b	al Hyg	3e C		(First, Middle, Last								, Maiden Sumame)		_
$\frac{\lambda}{a}$	should be ind Mental inarked c	To	James T	. Lawrence	ce					Floren	ce V. An	derson		
Mar	end 2 sho ealth and n 27 is m			lame/Relationship e V. Lawi								ner, City or Town, Sta m, MD 212		
$\mathcal{M}$ OO $f$ $\in$ $\mathcal{V}_i$ Baltimore, Maryland	Pages 1 enent of Hennit: If item			sposition  Cremation 3 [ 5 Other (Speci		State	cemetery,	isposition (in crematory of the control of the cont	or other pla		Öct 13 2006	20c. Location - City	or Town, State	
	permit. Departm imports eny inju		21. Signature of Fu	uneral Service Lice	fisee //- )	A	1,62	22 Mame	Pro Addi	ssylf Facility po	olitan Ch Baltin	napel More, MD		1
			23a. Part1. Enter t	the disease, or con art failure. List only	polications that	aused the dear	th. Do no	t enter the n	node of dy	ng, such as cardi	ac or respiratory a	ırrest,	Approximate Interval Between	
	Physician		Immediate Cause disease or condition	(Final	Ent	Lal A	100	thmi	~				Onset and Death	
	/Medical		resulting in death)	-	Due to	(or as a consec	uence of	):	0-					_
	Examiner		Sequentially list co	onditions,	b. H X1	POXIO								_
. /	bed ist	nlne	Sequentially list contains to in cause. Enter Under Cause (Disease or	erlying r injury	Due to	(or as a consec	quence of	1;						
V	axecui	Examiner	that initiated events resulting in death)	S	c. Due to	(or as a consec	quence of							Ħ
68760,	e be (	cai		l	d									
.89	rificate be executed og physicien and as the burial-transit	Medical												
P.O. Box	ne death cer the attendir thed for use	Physician/N	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 0 9 ☐ Unknown	2 months?	1☐Live b	tcome of pregna pirth 2 Peta nant at time of c own	al death	3 ☐Ectopic 5 ☐ Other		у		23d. Date of Month	f delivery Day Year	
o.	that the ned by detect	by Ph	Part II. Other signi	ificant conditions	contributing to d	eath but not res	sulting in t	he underlyin	ig cause gr	ven in Part I.	23e. Did	tobacco use contribu	te to the cause of death?	-
rds	v requires been sign should be										10	Yes 2 □ No 3 □	Probably 4 Unknown	
Division of Vital Records,	: The law requ cate has been page 2 shoul	Completed						<del></del>						
ital	sicien: certifica rector, p	Be C	25. Was case refer	rred to medical						26. Place of De	1 ☐ Yes	- 0 - 1 to - 1 - 1 - 1	Tes 252 140	-
>	hysic li direc	10 E	examiner?	No	Hospital: 1 □ I	Inpatient 2	ER/Outp	atient 3	DOA		Home 5 ☐ Res	idence 6 Other (	Specify)	
o uoi	nding Ph th. : After th e funeral		27. Manner of Deal 1 ☑ Natural 2 ☐ Accident	th 5 ☐ Pending investigatio		of Injury th, Day Year)	28b. Tin Inji	ne ot	28c. Inju Wo	ryat rk? ]Yes 2 □No	28d. Describe	how injury occurred		
Divis	f or Attend after death Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury - At h	iome, farm	, street, fac	tory, office		28f. Location ( City or To	Street and Number own, State)	or Rural Route Number,	-
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier (Check only one)	1☐ Certifying Pl 2☐ Medical Exa	miner: On the b	best of my kno asis of examina ner stated.	owledge, ation and/	death occurr or investigat	red at the ti	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
_	within To the	Me	29b. Signature and	title of certifier	//	71			29c. Licens	se number		29d. Date signed (M	fonth, Day, Year)	_
	0			Ul	1 4	36			000	5443	28	10-11.	-6	
	3		30. Name and add	ress of person who	completed caul	of death (Iter	m 23a) (T	/pe, Print)		200	00:	2 Baltim	-00 0	
	Sta	10	31. Date filed (Mon	nth, Day, Year)	32. F	9000 Registrar's Signa	ature	7111	11\ >	41121	5 NIING	2 DO ITIM	21 8 MV 2123	4
	Registr		0.0	OT 1 6 200	16		1	HARAGE S	,					

		•	1 - State Amrnd #1 P	er Phy G860 I	6766	artment of H rtificate of I	lealth and N <i>Death</i>	nental Hyg Re	en 2006	32604
			Decedent's Name (First, Middle, La	ist)				2. Date of Deat	h	3. Time of Death
	Physicia	_	e colon	Richard M	ure	Love		Month	Day Yee 200	. Latas DM
,	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or	r Location of Death	00,000	4c. County of De	
		eı		0 - 1	ical Conter	Ralti	more (	~ <u>~</u> .	i knite	d States
<u></u>				( CCC	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			1₩ 2□F 52		Months Days	Hours Min.	8. Date of Birth (Month, Day, 03/19	/1954 MD	Country)
		-	Usual Residence of Decedent							
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary Feb	ŏ	MD Baltim	ore City E	altimor	e				1 <b>∑</b> Yes 2 ☐ No
	the 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	within 72 hours after deeth with the Maryland ene. then "natural", or llema 23e or 28e-f ehow fra Marical Examinar most be notified at	0	3330 Wilkens Ave	nue		21229			United St	tates
	eeth	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.1		lispanic Origin? (Sc	ecify Yes or No-	14. Race - Ar	nerican Indian,
	lterr	Ë	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 1 No	10.0.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wi	
36	rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: B.	lack
5-0036	hou tura	pa	15. Decedent's E		16a, Dece	dent's Usual Occup	ation		16b. Kind of Busines	
5	n 72	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done	during most of work	ing		Industries
2121	with ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Jani	tor				
2	Hygid Hygid Sther ant, II	Ö	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
and a	Mental Merital arked o	Be	Willie Murel	,			Veronica	R. John	son	
Ž	should I	J.	40. I.f	(Time Driet)	10h Mailie	n - Address /Ctrast	and Number or Ru	m / Pouta Numbas	; City or Town, State	Zia Cada)
Maryland	2 short and 1 le m		19a. Informant's Name/Relationship Mrs. Veronica R.		4117				e, MD 212	1
ď.	s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23s or 28s-1 show other traumatic event, I'm Madical Examinar mast he notified at		20a. Method of Disposition		o. Place of Dispo				20c. Location - City	
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny injury or other 9069.		1 Burial 2 Cremation 3	Removal from State	cemetery, crei	matory or other plac	ce)	Oct 14		
Ξ	Pag ment: ury		4 Donation 5 Other (Spec		Chesapea	ake Crema	tory Inc.	2006	Beitsville	e, Maryland
<u>a</u>	Depention Dependent Important Information		21. Signature of Funeral Service Lice	Moog	80 2	2. Name and Addre Cremation	ss of Facility and Funera	al Altern	atives	
<u> </u>	207 2 2		HW			8717 Green			<del> </del>	Maryland 21286-
Н			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the d	eath. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arri	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	00000	0 Ja	D : 1				Onset and Death
Ť	/Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	1212415	20			30 MININGS
	Examiner			Clarence	- 00	× 0000	ailure			5'Hears
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):	1 200				3 gens
	pe l	nln	Cause (Disease or injury		20 years					
	and all-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	0 10	0-0-0			3-13
68760,	icate be executed physicien and s the burial-transit	aiE								
387	icate phys s the	edical		a				·		
_			IF FEMALE:	23c. If yes, outcome of pre	onancy				23d. Date of	doliven
Вох	eath certif attending for use a	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	у		Month	Day Year
o.	The law requires that the death certi ste has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	or death 3L	_ Other (specify) _				
P.O.	hat the d by	F	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause an	ven in Part I	23e. Did to	bacco use contribute	to the cause of death?
s,	signe d be c	Ď	Tatti. Other significant constitutions	contributing to dodin but not	rosaking ar tilo a	induity ing occuso give		1 □ Y		Probably 4 Kunknown
Division of Vital Records,	w requir been si should	Completed							1	
Ö	has b	ple						24a. Was a autops	sy prior	autopsy findings available to completion of cause of
<u> </u>	The ate h page	Į.						perfori 1 ☐ Yes	méd? death 2.000 1 ☐ Y	i? ′es 2 ☐ No
ita	ysician: The lis certificate hadirector, page	Be (	25. Was case referred to medical				26. Place of Dea	th (Check only or	16)	
2	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2	ER/Outpaties	nt 3□ DOA Oth	ner: 4 🗆 Nursing H	ome 5 Reside	ence 6 □Other (S	pecify)
0	9 Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o	of 28c. Injui	ry at	28d. Describe ho	ow injury occurred	
<u>ŏ</u>	ndin Ith. e fur	atlo	1 Natural 5 Pending 2 Accident investigati		,,,		Yes 2□No			
<u>vis</u>	Atte	=	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of injury - A		reet, factory, office		28f. Location (Si City or Town		Rural Route Number,
ā	al or s afte if Dir d in	Certification:	15000	building, etc. (Sp.				3/17 ST 10M		
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,			hysician: To the best of my						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	nminer: On the basis of exam and manner stated.	nination and/or in	ivestigation, in my o	opinion, death occu	rred at the time, d	ate and place, and o	due to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
			Yin Erahan	ovsen medic	ial Doct	05 Ve	3-000	6	ic below .	0 2006
	^		30. Name and address of nerson who	completed cause of death (	Item 23a) (Type	Print)			1000	Baltimaria
	7		Kim Frederickon	medical Drug	m The	Province (	Middle Cont	4940:	Fastern Aven	10. Mag lead 21,24
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Al a		,		1100 year 21227
	Regist		30. Name and address of person who kin Frederickson 31. Date filed (Month, Day, Year)	lo Marie de	7 A 500	San al				
					and the same of th					

			State of Maryla  1- State Registrar		artment of Health and rtificate of Death	,	•	32605
	Physicia	an e	1. Decedent's Name (First, Middle, Last)	NEA	-1	2. Date of De Month		3. Time of Death
0	/Medic	al	HERMAN AUGUSTUS	10617		10	1/ 06 4c. County of Dea	0318 M
	Examin Funeral Director	ω 	1, M 2 □ F	rs. last birthday)	4b. City, Town, or Location of Deat  Annapoli  If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	. S Date of Bir (Month, Da	Anne Aru	
8	T		212-31-6437 Usual Residence of Decedent			TAPL ZI	1, 1930 Mai	
	farylar show ed at	ō		City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	Director	MD Anne Arundel H  10e. Street and Number	arwood	10f. Zip Code		10g. Citizen of What C	•
	th with 23a o 1st be		1074 Cumberstone Road		20776		United Sta	tes
	er dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No to Rican, etc.)	14. Race - Am Black, Whi	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 【★No Specify:		Specify: Black	
21215-0036	72 hou natura lical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	rking	16b. Kind of Business	/Industry
21	vithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wo DO NOT use retired)	rang	Agricultu	re
d 2	filed v Hygie other t	ပ္ပ	12. 17. Father's Name ( <i>First, Middle, Last</i> )	Land	scaper 18. Mother's Nai	ne (First, Middle	, Maiden Surname)	
lan	Ald be fental rked c	To Be	Samuel Augustus Neal		Jessie	Collin	S	
Maryland	2 shou and N is man		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or R			,,
	1 and Health sm 27 ther tr	-	Charolette Green/Daughter 20a. Method of Disposition 20b		D Victor Parkway	Annapol	is, MD 2140	
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show int: If item 27 is marked other than "natural", or items 2ae or 28a-f show other traumatic event, the Medical Examiner must be notified at		Tabunal 2 Ociemation 3 Onemoval nom state		osition (Name of matory or other place)	Oct 17 2006	Owensville	
altir	# F 모 글	ŀ	21. Signature of Funeral Service Licenses		emorial UMC 2. Name and Address of Facility			-
õ	permi Depar Impor any ir		Melinda Mar SX		Miller's Metropo 1922 Forest Driv	e Annar	polis, MD	
			23a. Part1. Enter the disease, or complications that daused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	ter the mode of dying, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Depth
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consideration of the control of the contro	A To	re leing C	h		more
	Examiner			squence ory.				
	D #	iner	Sequentially list conditions,  Queeto lor as a consider of the consideration of the considera	e quence of):				
V	xecute and II-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a cons.	equence of):				
68760,	icate be executed physician and s the burial-transit	edical E	d					
			IF FEMALE:					
Вох	The law requires that the death certific ate has been signed by the aftending prage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	etal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	rueaui 5L				
	es that gned b	by Pi	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause given in Part I.		tobacco use contribute t	
Division or Vital Records,	w require been sign					1 🔯	Yes 2□No 3□P	robably 4 □Unknown
Rec	ne law has b je 2 sl	Completed				24a, Was auto perfe		utopsy findings available completion of cause of
tal	sician: Th certificate rector, pag		25. Was case referred to medical		26. Place of De	1  Yes ath (Check only	2 No 1 Ye	s 2 No
Z	nysicia nis ceri direct	To Be	examiner?	☐ ER/Outpatier	Other:		idence 6 ☐Other (Spe	ecify)
n o	ding Phys n. After this funeral di	:uo	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time o Injury	Work?	28d. Describe	how injury occurred	
Sio	I or Attend after death. Director: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At	home, farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location /	Street and Number or F	Bural Route Number.
<u>&gt;</u>	al or A s after Il Dire	Certification:	4 Homicide determined building, etc. (Spe	cify)		City or To	wn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my keep one to the basis of examinand manner stated.	nowledge, deat ination and/or ir	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the urred at the time	cause(s) and manner a , date and place, and du	s stated. le to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	6	29c. License number	/	29d. Date signed (Mon	th, Day, Year)
	0		Three of worth	NI	0 214 38		10/11/06	
	7		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print) FYENSE HIG	HUM	ANNAPOU	1 MD21401
I	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	inature	de		•	,

		1 - For State Registrar	State of Maryla		artment rtificate			and M		giene Reg. No:		6 3	3260	06
Physic	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day	Y	'ear	3. Time of D	
/Medi	cal	4a. Facility Name (If not institution, give s	Randolph H	iram Ow	ens 4b. City, T	OMB OF	Location		Octobe1		200 County of		1:45	P <sup>M</sup>
Examir	ner	Manor Health of V			Wheat		Location	) Deall			ontgo			
Funeral		5. Social Security Number 6. Sex	7. Age (In vi	rs. last birthday)	If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Day	h			e (State or	Foreign
Director		212 03 1190	M 2□F 9]	Yrs.	IVIOTIOIS	Days	Tiodis	IVIIII.	Apr 18	, 19	15 N	Maryl		
and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation							10d.	. Inside City	Limits
Mary -fah	ţ	MD Montgomen	v Si	lver Sp	ring								1 X Yes 2	2 🗌 No
th the	Director	10e. Street and Number			10f. Zip 0	Code				10g. Citiz	zen of Wh	at Country	?	
ath wi		726 University Bo	oulevard Wes		209						5.A.			
er de litems	Funerai		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)	. 1		American White, etc		
D36	b	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1XXYes 2 ☐ No If Yes, Give Year or Dates: 194	5-46	1 ☐ Yes 2	<b>X</b> No	Specify:				Specify:	White	ž	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f ahow aumatic event, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual kind of work	Occupa	tion	t of working	200	16b. Kir		ness/Indus		
Mithin 19	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	umg most	OI WOINII	, y					
d 21		17. Father's Name (First, Middle, Last)	5+	Acco	untant		18 Mothe	r'e Namo	(First, Middle,			ction	1	
and d be f antal h	To Be	Walter Owens							holfart		Surrame)			
arylanc	F	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (	(Street a			Route Numbe		Town, St	ate, Zip Co	ode)	
Ore, Maryla es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		Linda Logsdon /d	laughter	726	Univer	sity	y Blv	d. W	est, Si	lver	Spr	ing,	MD 20	901
OTE ges 1 a t of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b	. Place of Dispo cemetery, cre-	osition (Name matory or oth	e of ner place	)	D	ate	20c. Loc	cation - Ci	ty or Town	, State	
Baltimore, Maryland 21215-0036 bermit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. mportent: if tiem 27 is marked other than "natural", or my nitury or other traumatic event, tre Madical Examples.		4 ☐ Donation 5 ☐ Other (Specify)	F	ort Lin					3, 06		twoo	d, Ma	rylan	d
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License	1///	00773 3	2.Name and onalds 13 Tal	Address on E bott	of Facility Funer Ave	al Ho . La	ome, P. urel, M	A. Maryl	and	20707	-4389	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de e cause on each line.	eath. Do not en	ter the mode	of dying	, such as	cardiac oi	r respiratory ar	rest.		In	pproximate iterval Betwe inset and De	en ath
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Alzheimer		ase									
Examiner			Due to (or as a cons	equence of):										
	Je.	Sequentially list conditions, if any, leading to immediate	Due to for as a cons	aquence of):		-								
P. cut of ransiti	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a cons	equence of):										
5876 icate b physic s the b	dicai	d										-		
9 5 6	Physician/Me	IF FEMALE:	3c. If yes, outcome of preg	gnancy						2	3d. Date o	of delivery		
death cert death cert e attendin d for use	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fe 4 Pregnant at time o		⊒Ectopic pred ⊒Other (s <i>pe</i> d						Month		ay Ye	ar
P.O. at the de de de de de de de de de de de de de	hys	9 Unknown	9□ Unknown											
- E D B	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cau	use give	n in Part I.			obacco us obacco us			cause of dea ly 4 ⊠Un	
aw re	Completed								24a. Was		24b. We	re autopsy	findings av	railable
The lav	E O								autop perfor	rmed?	dea	ith?	No	120 01
Vital Fiderian: The certificate rector, pag	Be	25. Was case referred to medical examiner?				F -			(Check only o					
VISION Of VITA Attending Physician: r death. ector: After this cartific by the funeral director,	2	1 ☐ Yes 2 🔀 No	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier	_		4 K INUI		ne 5 Resid					
On Of	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	c. Injury Work 1	es 2∐N		ou. Describe i	iow injury	, 00001180			
DIVISION OF VITAL HECORDS, I or Attending Physician: The law requires I after cleath. Director: After this certificate has been signs in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, str cify)	reet, factory,	office		2	8f. Location (S City or Tow			or Rural R	oute Numbe	эг,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Examin	ician: To the best of my ker: On the basis of exami	nowledge, deat	h occurred at	t the time	e, date and	d place, a	nd due to the o	cause(s) a	and mann	er as state	ed. e cause(s)	
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	1)		License						Month, Day		
		1 Cellon R	. I pa	all	1 D	5226	1			Octol	ber 1	2, 2	006	
~X		30. Name and address of person who con			Print)								-	
65% and 400		Alan R. Segal, M. 31. Date filed (Month, Day, Year)	D. 1517 Hug 32 Registra/s Sig		le, Si	lver	Spri	ing,	MD 209	06				
Sta Registi	_	OCT 1 6 2006		Ro A	2000									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

11- For Amend item#5,10b,14,19a, perril, Inf, Col. 10/20/06 III

1- Registrar Amend item#5,10b,14,19a, perril, Inf, Col. 10/20/06 III

Reg. No. 32607 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11:49 AM Osama Osman 2006 Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of 5. Social Security Number 4140 Baltimore of Manyland Medical Cento If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 03 21 79 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) **X**□M 2□F Months Pakistan 27 Director 35-02-<del>3896</del> Usual Residence of Decedent death with the Marylend 10b. County Baltimore Show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28e-f shor Funeral Director 1 ☐ Yes 2 X No MD Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3212 Peddicoat Ct. 21163 Pakistan 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Ita 1 Never Married 2 Marned Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled Disabled na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Abid Osman Batool Osman 19a. Informant's Name/Relationship *(Type, Print)* **Osman Abid Osman** Abid <del>Shan</del> Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abid 3212 Peddicoat Ct, Woodstock, Md 21163 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ permit. Page Department of Important: If any Injury or once. King Memorial Park 10/12/06 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Ovome Humpson 4300 wabash Ave, Baltimore, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or # a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the deeth certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Certification: To Be Completed by Physician/Medical ettending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Hypertersion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 M No Director; After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation t 🖪 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarel C Hospitel 1 Certifying Physician: To the best of my knewledge death contined at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of pertific 29c. License number 29d. Date signed (Month, Day, Year)

2

State Registrar 22 South

P19694

Greene St Boltimore, MO

11, 2006

MO

Dittman

16

C.

31. Date filed (Month, Day, Year)

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

MQ

32, Registrar's Signature

		•	For State Registrar	State of Ma	ryland / [	Department Certificate	t of Hea e <i>of De</i>	alth and Neath	1ental Hy	giene (	106	326	08
1			Decedent's Name (First, Middle, L.	ast)					2. Date of Dea Month	ath Day	Year	3. Time of	Death
1	Physicia		Velda Natoma	Pvles					Octobe:		2006	9:55	P M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City,	Town, or Loc	cation of Death		4c. Cou	unty of Death		
100		ja e	Laurel Regional	l Hospital		Lau	rel			Pri	nce Ge	orge's	
, i	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last bir	thday) If Under	1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	Cour	lace (State o	r Foreign
	Director		213-14-8357	1□M 2XF	84	Yrs.	-,0		Nov. 1	2, 192	l Mar	yland	
-,-	p _		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loostian					1	0d. Inside Ci	ty Limits
	aryla shov	_			Too. Oily, Tow	II OI LOCALIOII						1√XYes	
	8a-f	cto		George's	Lau					10- Chinas	of What Cour		
	within 72 hours after death with the Maryland one. Itan "natural", or items 23a or 28a-f show the Marical Examinar mant be notified at	Director	10e. Street and Number			10f, Zip		_				itry :	
	ath v		44 B. Street			42.111	2070		4. V N-	US	Race - Americ	an Indian	
	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XX		If Yes, spec	offy Cuban, N	Mexican, Puerto	ecify Yes or No Rican, etc.)	14.	Black, White,		
36	s aft	by F	1 ☐ Never Married 2 ☐ Marned  3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	0	1 🗆 Yes	2 <b>XX</b> No S	Specify:		Sp	өсіfу: Wh	ite	
Ş	hour		15. Decedent's I		16a	. Decedent's Usua	al Occupation	n		16b. Kind	of Business/In	dustry	
5	n 72	Completed	(Specify only highest g	rade completed)		(Give kind of wo	rk done durir se retired)	ng most of work	ding .			,	
2	thar thar	E	Elementary/Secondary (0-12)	Coltege (1-4or 5-		ookkeepe	r			Sand	& Gra	vel	
0	illed Hygie other ent, it		17. Father's Name (First, Middle, Las		12	0000		. Mother's Nam	e (First, Middle,	Maiden Sui	mam <i>e</i> )		
an	id be ental ked o	To Be	George E. Dive	n				Marv	Eva Geis	5			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heathi and Mental Hygiens f Heath and Mental Hygiens them 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating resist the notified at	-	19a. Informant's Name/Relationship		196	. Mailing Address	(Street and				wn, State, Zip	Code)	
	9 £ 1 = 0		Margaret Lewis/	Sister	4	4 B. Str	eet, 1	Laurel,	MD 20	707			
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place o	f Disposition (Nar.	ne of		Date	20c. Locat	ion - City or To	own, State	
9	Pages nent of I ant: If its ury or o		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			rection		10/1	7/2006	Cli	nton,	MD	
Baltimore,	설립하다.		21. Signature of Funeral Service Lic		1				onaldson	n Fune	ral Ho	me, P.	Α.
ä	Depa Impo eny l		Warring h	10 de 100	0160	313 Ta	lbott	Avenue	, Laure	L, MD	20707		
was.			26a. Part I. Enter the disease, or co	mplications that caused	the death. Do							Approximat Interval Bet	e ween
	Physician		shock, or heart failure. List on Immediate Cause (Final			Ovarian	Canaa	20				Onset and	
	/Medical		disease or condition resulting in death)	_ a	scattc consequence		cance	<u>L</u>					
	Examiner												
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):							
)^	od ansit	Examiner	Cause (Disease or injury that initiated events	C.									
ó	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a	a consequence	of):							
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	icai	,	d									
68	ng pt	Med	IF FEMALE:							-			
Вох	th ce tendi	an/	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		a 3 □Ectopic pi	regnancy			23d	. Date of deliv Month		Year
	e dea he at hed fo	Sici	in the past 12 months?  1  Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (sp	pecify)			ļ		,	
0	Attending Physician: The law requires that the death certifica rideath.  ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as in by the funeral director, page 2.	by Physician/Med	9 Unknown	a contain ation to double by	it not consilting	in the madeshine a	i	in Dad I	23e Did t	obacco use	contribute to t	he cause of o	death?
	res tha igned be del		Part II. Other significant conditions	s contributing to death bu	it not resulting	in the underlying t	ause given i	inraiti.			to 3 Pro		
Vital Records,	w requires t been signe should be	Completed											
S S	las b	pie							24a. Was	psy	4b. Were auto prior to co	opsy findings impletion of c	available ause of
<u> </u>	The tate t	Son							1 ☐ Yes	rmed?	death?	XXNo	
ita	Physician: The law r this certificate has t oral director, page 2 s	Be	25. Was case referred to medical examiner?				-	6. Place of Dea	th (Check only	опе)			
	thysi this c	2	1 ☐ Yes 2 💢 No	Hospital: 1 Mpatie					ome 5 Resi			fy)	
D C	After Unerg	on:	27. Manner of Death  XXNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		Injury	28c. Injury at Work?		28d. Describe	now intury o	ccurred		
<u>s</u> .	tend leath tor: /	cat	2 Accident investigat 3 Suicide 6 Could not	he	11 hama 6	M		s 2 No	28f. Location (	Street and A	lumber or Rus	nl Poute Nun	nhar
Division of	or At fler of Direction by	Certification:	4 Homicide determine	28e. Ptace of Inju- building, etc		arm, street, factor	у, опісе		City or To		iumber or riur	ai rioute riui	1001,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier Certifying	Physician: To the best of	of my knowledge	e death cooursed	at the time	date and place	and due to the	cause(s) an	d manner as	stated	
	Hos Fun Fun	Medical	(Check only 2 Medical Ex	eminer: On the basis of and manner sta	examination a	nd/or investigation	n, in my opini	ion, death occu	rred at the time,	date and pla	ace, and due	to the cause(:	5)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	2.10		29	c. License n	umber		29d. Date s	igned (Month	Day, Year)	
1	⊢≯≓ŏ		Marson	O. rue	tzw		D2374	43		OCto	ber ll	. 2006	
•	入		30. Name and address of person wh		3		2231				~~	, 2000	
	1		Martin Weltz	7525 Gree			ive (	Greenhe	1+ MD				
	95 - Q1-	ate	31. Date filed (Month, Day, Year)		ar's Signature	CITCUL DI		OT CCIING	LU, FID				
	Regist		OCT 1 6	2006	as a Ma	Breit	9						
				AT WATER TO SEE	A STATE OF THE PARTY OF THE PAR								

			1 - For State Registrar		State of M	aryland	,	partment e <i>rtificate</i>			Mental F	lygier Reg. 1	2006	32609
	Physici	an	1. Decedent's Nan	ne (First, Middle, La							2. Date of Month	Death [	Day Year	3. Time of Death
	/Medic	al	An Facility Name	Charles	S J street and number)		Pil		Faura 01	r Location of Deal			4c. County of Death	9:00 A <sup>M</sup>
	Examin	er		an Hospita					thes		tt I	'		
	Funeral		5. Social Security	Number 6. S	ex 7. Aç	ge (In yrs. I	ast birthda	y) If Under	1 Year	If Under 24 Hrs		Birth	Montgome 9. Birthi	place (State or Foreign ntry)
	Director		710-10-	-2134	<b>⊠</b> M 2□F	90	Yrs.	Months	Days	Hours Min.	Octobe	er 8,	,1916	PA
	and		Usual Residence of 10a. State	10b. County		10c. City	, Town or	Location						10d. Inside City Limits
	Maryl -1 sho	tor	MD	Montgom	erv	Pot	omac						,	1 ☐ Yes 2 🛣 No
	h the	Director	10e. Street and No			100	omac	10f. Zip	Code			10g. (	Citizen of What Cou	ntry?
	23a c	ralD	9440 New	bridge Dr					.085				USA	
	er des items	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?	S. 13	<ol> <li>Was Deced If Yes, spec</li> </ol>	ent of H ify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or to Rican, etc.)	No-	14. Race - Ameri Black, White,	
36	irs aft	by F		ried 2⊠ Married 4 □ Divorced	1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	№ 193 194	_	1 ☐ Yes 2	™ No	Specify:			Specify: W	hite
Baltimore, Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. I have nother then "natural", or itema 23a or 28a-f ahow avent, the Madical Examinar must be notified at	ted	/5-0	15. Decedent's Ed	lucation		16a. Dec	cedent's Usua	l Occupa	ation during most of wo	ekina	16b.	. Kind of Business/In	ndustry
218	ithin 7	Completed	Elementary/Sec		College (1-4or	5+)	life	. DO NOT us	e retired	1)	rking			
2	2 should be filed within and Mental Hygiene. is marked other then sumatic avent, the Market	S	17 Eather's Name	(First, Middle, Last)	4		Civ	il Engi	lnee	18. Mother's Na	me /First Mid		S Governm	ent
anc	d be filed intal Hygi sed other	Be c		an Pilch						Hedwig			ien Sumame)	
<u> </u>	Shouk nd Me mark mark	ို		liii FIICII Name/Relationship (	Type, Print)		19b. Ma	iling Address	(Street				y or Town, State, Zij	p Code)
₹	alth ar		Florenc	ce A. Pilo	h/Wife		9440	) Newbr	idg	e Drive,	#314,	Pot	omac, MD	20854
Je,	of Her		20a. Method of Di	•	Removal from State	1 0	ace of Dis	position (Name	e of		Date		Location - City or To	
ij	Pag ment ant: if ury o			5 Other (Specif			. Jol	nn's Ce	emet	ery 10-1			esburg, V	
Salt	permit. Pages 1 and 2 should be Deperment of Heelth and Menta Important: If Item 27 is marked any injury or other traumatic av		21. Signature of	uneral Service Lice	See (	20		22. Name and					uneral Ho	
	40 E 4 0	_	227 Parti Fark	the disease or som	plications that cause	d the death	Do not o						esburg, V	A ZUI/O Approximate
			shock, or ne	art failure. List only	one cause on each I	ine.			o or ayın	g, such as cardia	c or respirator	y arrest,	:	Interval Between Onset and Death
1	Physician /Medical		disease or conditi resulting in death	ion	a Due to (or as	<u>ع ح</u>	PS	15						
	Examiner							MON	1A					
1 7	n =	ner	Sequentially list of any, leading to cause. Enter Und Cause (Disease of that initiated even	onditions,	Dua to (or as						_			-
V	ecuted and -transi	Examiner	Cause (Disease of that initiated even resulting in death)	r injurý ts Last	C			ARY	T	RACI	iNI	EC	FION	
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	al E	100011119 117 002117)		Due to (or as	a consequ	ence or);							
587	ficate g phys	edical			d									
×	eath certif attending for use as	N/M	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome	of pregnal	ncy						23d. Date of deliv	rery
SS B	death	Physician/M	in the past 1: 1 Tes 2	2 months? □No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			B⊟Ectopic pre B⊟ Other (spe				_	Month	Day Year
P.O.	that the de ed by the detached	Phys	9 Unknow											
	signed be dei	Š	Part II. Other sign	ificant conditions o	ontributing to death t	out not resu	Ilting in the	underlying ca	use give	en in Part I.	1		co use contribute to t	the cause of death? bably 4 Unknown
Chai	w requir	Completed										-	_	
Ae C	ne law has ge 2 a	mpi									24a. W au pe	ras an itopsy erformed	? death?	opsy findings available ompletion of cause of
<u>≡</u> ≥	ician: Th certificate rector, pag	ဝင	25. Was case refe	erred to medical						26. Place of De	1 □ Ye	s 2,21	No 1 ☐ Yes	2.2 No
<u></u> 2≥	Physician: The Ithis certificate had director, page	To B	examiner? 1 ☐ Yes 2 ☐		Hospital: 1 Inpati	ent 2 🗆 1	ER/Outpati	ient 3 DO	A Oth	0.0			6 ☐Other (Specia	fy)
0 0	Attanding Physician: r death. ector: After this certifice by the funeral director, p	L:uc	27. Manner of Dea	ath 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time Injury	of 28	3c. Injury World		<del>,</del>		njury occurred	
sio	eath. or: Al	catic	2 Accident	investigation				М	1 🗆	Yes 2 □ No				
Division	P age i	Certification:	4 Homicide	dotominad	286. Place of in	ijury - At ho tc. <i>(Specify</i>	me, farm,	street, factory	, office			n (Street Town, St	and Number or Rur ate)	al Route Number,
_	Hospital		29a. Certifier	1 Certifying Ph	ysician: To the best	of my know	wiedge, de	ath occurred a	at the tim	ne, date and plac	e, and due to t	he cause	e(s) and manner as s	stated.
	Ma Hos	Medical	(Check only one)	2 Medical Exar	niner: On the basis of and manner st	of examinat	ion and/or	investigation,	in my o	pinion, death occ	urred at the tim	ne, date a	and place, and due t	to the cause(s)
	To the within 2 To the complet	Z	29b. Signature an	d title of certifier		1		290	_	e number		29d. I	Date signed (Month,	Day, Year)
			<b>P</b>		Luny	13cm	SU	20	00	1053	124		10181	06
	10		30 Name and add	dress of person who	completed cause of	death (Item	23a) (Typ	e, Print)	DV	Pa	Dist	0 N/	VD 208	50
	Sta	te	31. Date filed (Mo	nth, Day Year)	32. Regist	rar's Signat	ture 🥒	111-61	VI	IV, NU	NIII	<u> </u>	NI QUO	
	Registr		00	T 1 6 2006	Allen S.	J.	Got	all s						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROBERT WILLIAM PARKS OCTOBER 12, 2006 8:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON r 1 Year If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1₩ M 2□F 218-22-9254 Director 78 6/1/1928 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director 1 ☐ Yes 2 X No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner must be 1110 LITCHFIELD ROAD 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🗓 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC 9TH GRADE TOWSON FORD rages 1 and 2 should be finent of Health and Mental Hint; If Item 27 is marked over y or other finents. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERTRAM PARKS EDNA SANDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS R. PARKS/WIFE 1110 LITCHFIELD ROAD TOWSON, MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If Iter
any Injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 10/16/2006 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON. 23) Post. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years olorecin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 UCTOSEL 13 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Browne no 21204 AARIN Charles mo 6565 N. Cheves st 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2006 Registrar

Rober

#### Places Type or Print in Black Indelible Ink

Ronald F Rosser		State	of Maryland						ene				
Tronaid Triosco.		1 - For State	or waryland		tificate of		2110 11101111	a. 117 g. c		. No. 20	06	3261	
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Las	st)	<u> </u>				2. Da	ate of Death		Ť	3. Time of Death	
Medical Examin				osser		0: 7			onth ctober 12	2006 4c. County of		0649 hrs	
		4a. Facility Name (if not institution, given Shady Grove Adventist H			41	Rockville	or Location of	Death		Montgom			
Funeral	-	5. Social Security Number 6. S		e (In yrs. la	ast birthday)	If Under 1	Year If Under	24Hrs. 8 [	Date of Birth	(MM/DD/YYYY)	9. Birt	nplace (State or Foreign	
Director			XM 2 F	64	Yrs.	Months [	Days Hours	Min. J	une 4	, 1942	Ma	ryland	
	H	Usual Residence of Decedent				<u> </u>							
* any		10a. State 10b. County			Town or Location							10d Inside City Limits 1 Yes 2 X No	
rland -f shor	ট্	Maryland Montgom	ery	D	ickerso		-		110	. Citizen of Wha	at Cour		
r 28a	Director	10e. Street and Number				10f. Zip Coo			100				
ith the		18515 Wasche Roa	.d 12. Was Decedent	Ever in U.	S. 13. Was		0842 Hispanic Origin	n? ( Specify	Yes or No-		J.S.	A • can Indian, Black,	
eath w	Funeral	1 Never Married 2 Married	Armed Forces?				ıban, Mexican, I			White	etc.		
ifter d	by Fi	3 Widowed 4 Divorce	If Yes, Give Year		1 🔲	Yes 2	No specify:			Specify:		ite	
nours a	gp	15. Decedent's Education (Specify of	· · · · · · · · · · · · · · · · · · ·		16a. Decedent during mo		upation (Give ki		ione	16b. Kind of Bus	iness/li nerv	dustry County	
36 in 72 h han "1	Bet	Elementary/Secondary (0-12)	College (1-4 or :	5+)	Twanan		on Cupo	mui ao			_	ool System	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Completed	17. Father's Name (First, Middle, Las	_		Transpe	ortati		pervisor Tability Balting By Balt					
215 oe filed tral Hy ked o	Be	Lee Rosser					E1	lizabe	th D:	impter			
	힏	19a. Informant's Name/Relationship (						Number or Rural Route Number, City or Town, State, Zip Code) Oad, Dickerson, Maryland 20842					
MD nd 2 sho alth and m 27 is		Jean Marie Rosse	r - Wife	206	1851.			l, Dic		n, Maryl 20c. Location -			
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3	Removal from St	ate	crematory or oth	er place)					-		
timent trant:	-	4 Donation 5 Other Specif		Me								a, Virginia	
Bal permi Depar Impo		21. Signature of Funeral Service Lice		-	1					Funeral s, Maryl			
Physician		23a. Part Enter the disease, or com		the death	Do not enter th	e mode of dy	ing, such as ca	ardiac or resp	piratory arre	st, shock, or hea	rt	Approximate Interval Between Onset and	
Medical		failure. List only one cause on e Immediate Cause (Final disease a	ach line. Multiple Injuries	3								Death	
Examiner		or condition resulting in death)	Due to (or as a cons		f):								
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence o	f):	_	-						
	Examiner	cause. Enter Underlying Cause											
ecuted and - transit		events resulting in death) Last	Due to (or as a cons	equence o	т):								
= = e	dical	UNPENDED	AMENDED										
* 0 O F	Med	IF FEMALE:	23c. If yes, outco	me of preg	nancy					23d. Date of	delivery		
Box 68760 e death certificate b the attending physic	sician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant a	t time of de	oth	al death		pregnancy		Month		Day Year	
30x death of e atter	ysic	1 Yes 2 No 9 Unknow			5 Oth	er (Specify)				1			
P.O. E	/ Phy	Part II. Other significant conditions	contributing to deal	th but not r	esulting in the u	nderlying cau	use given in Par	rt I.			_	the cause of death?	
ires that signed	d by							— II		257, 1924		pably 4 Unknown	
ords,	Completed			_				''	24a. Was a autops	y p	rior to c	topsy findings available completion of cause of	
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si	mo								perform 1 Yes 2		eath? ✓ Ye	es 2 No	
ian: Tertific	Be C	25. Was case referred to medical examiner?	Heenital:				Place of Death (		panen,				
F Vit	5	1 Yes 2 No		ent 2	ER/Outpatient		Injury at Work	Nursing Ho		Residence 6 ow injury occurre	Other	•	
n of \ding Phy h After the funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month Day) Oct 12, 2006	Year)	0555 hrs		Yes 2	lDriv		xed object o		n	
Division of Vital Records, rate or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should the law in by the funeral director.	Certification:	2 Accident Investiga	28e Place of I	niury - At h	ome, farm, stree				Location (S	treet and Number	er or Ru	ral Route Number, City	
Divi	ertif	3 Suicide 6 Could no determin	ot be						or Town, St 01 Old R	<sup>ate)</sup> i <b>ve</b> r Road, F	ooles	sville, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physi	cian: To the best of n	ny knowled	ige, death occur	red at the tim	ne, date and pla	ice, and due	to the cause	e(s) and manner	as star	ted	
o the vithin. To the omple	Medical	one) 2 Medical Examin	er:On the basis of exa and manner stated	amination a	and/or investigat			curred at the	time, date a				
FSFS	29b. Signature and title of certifier						cense number			29d. Date sign			
		Jasheld	e in	4)			).C.M.E.			October 13	, 200		
BU		30. Name and address of person who Tasha Greenberg MD.	o completed cause of Assistant Medic			Penn Stre	eet, Baltimo	re, MD 21	1201				
9	ate					-							
Regist			6 Surgera	, B	Court								

			1 - For State Registrar	State of I	Maryland /	Departr Certifi	nent of H	lealth an Death	d Mental Hy	gient		326	12
	Physici	an .	1. Decedent's Name (First, Mid Madeline	die, Last) B •		Sko	arski		2. Date of De Month Octobe	Da	3 2006	3. Time of t	Death M
	/Medic Examin		4a. Facility Name (If not instituti		er)		City, Town, or	Location of D			County of Death		
			Heritage C		A // /- /- /- /- /- /- /- /- /- /-		ındalk	If Under 24	Hre la D (B)		_Baltimo		. F
п	Funeral Director		5. Social Security Number 213 – 20 – 7211	6. Sex 7.	Age (In yrs. last b	Yrs. Mo	Inder 1 Year nths Days		Min. 8. Date of Bin (Month, Date of July 2	ay, Ye <i>ar,</i>		nplace (State or untry) aryland	' Foreign
	D		Usual Residence of Decedent  10a. State 10b. Coun			wn or Locatio				7 17	20 118	10d. Inside Cit	- Limite
	Maryfa f show	ō	Maryland	NA	7.	imore	11					1 ☐ Yes	•
	or 28a	irec	10e. Street and Number	1111	Бате		of. Zip Code			10g. Cí	itizen of What Co	A untry?	
	ath wil	raic	6703 Boston A				21222				U.S.A		
36	rs affer de l', or Items zaminar n	by Funeral Director	11. Marital Status  1X Never Married 2 Married 2 Married 2 Divorce	If Yes, Give	is? ⊑ <mark>y</mark> No		Decedent of Hi , specify Cuba 'es 2 No	ispanic Origin in, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)	>-	14. Race - Amer Black, White Specify:		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show entry injury or other treumatic event, the Medical Examinar must be notified at once.	Completed		ent's Education nest grade completed)	16	(Give kind	Usual Occupa of work done of DT use retired	durina most of	f working	16b. H	Kind of Business/l	ndustry	
2	iled wi tygien her th	Con	10 17. Father's Name (First, Middle	NA NA		Book	Keeper	10 Mathada	Name (First, Middle		anking		
Maryland	ld be fi ental F ked ot Ic ever	To Be	John	M.	На	us			ephine	, Maidei	Siga	i	
ary	and M	-	19a. Informant's Name/Relation	nship (Type, Print)	19	b. Mailing Ad	-	and Number o	or Rural Route Numb		or Town, State, Z	ip Code)	
رب ≥	and 2 lealth m 27		Barbara Ferra	ra (Neice		713 Pe		el Way	Baltimore Date				
Baltimore,	ages 1 nf of H t: If ite / or ot		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other		te cemet	ery, cremator	y or other plac	0	ctober 16,		ocation - City or		
alti	mit. P partme sorten r injury		21. Signature of Funeral Service	24	Holy	22. Na	Cemetone and Address	ss of Facility			dalk, Ma	100	
<u>~</u>	Depa Impo eny ir once.		Mark	O. Chops	och-	100	Dabrow 5 Dund:	wski/Cl alk Av	hojnacki I e. Baltimo	lune:	ral Home Marvlan	s P.A.	
2	Pnysician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complications that cause only one cause on each	sed the death. Do	not enter the	mode of dyin	g, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
	/Medical- Examiner			Due to (or	as a consequence	. ~	ric !	STE	M6515	į.			
	D 150	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	e of):			2				
	icate be execufed physician and s fhe burial-fransif	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence	→ <del>}</del>	TEK	Y _	DISETA	52			
8760,	ysiciar ne buri	cai		1 SCH	EMIC	BOL	AEL	DIS	EBSE				
9	artifica ling ph e as fh	Medi	IF FEMALE:										
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		i 2 ∏Fetal deat t at time of death		pic pregnancy er (specify)				23d. Date of deline Month	,	'ear
<b>Q</b>	uires that the de signed by the a lid be detached f	by	Part II. Other significant condi	tions contributing to deat	h but not resulting	in the underl	ving cause give	en in Part I.		tobacco Yes 2	use contribute to		eath?
Vital Records,	aw requir is been si 2 should	Completed							24a. Was		24b. Were au	opsy findings a	ıvailable
Ä	The lav	Com							— auto perfo 1 ☐ Yes	ormed?	death?	ompletion of ca	u36 Oi
Vita	sicien: certific recfor,	Be	25. Was case referred to medic examiner?	Hospital:			Othe	er /	Death (Check only				
Division of	To the Hospitel or Attending Physicien: The law Within 24 hours affec death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	ition: To	1 Yes 2 Yo  27. Mann of Death  1 Astural 5 Pend 2 Accident invest	28a. Date of I	- 1	Outpatient 3: Time of Injury	28c. Injury Work	4 Virtursii	ng Home 5 ☐ Resi 28d. Describe			<i>ħy)</i>	
Divisi	el or Attend s affer death il Director; /	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 286. Place of	Injury - At home, etc. (Specify)	farm, street, f	actory, office		28f. Location ( City or To		nd Number or Ru e)	al Route Numb	er,
	To the Hospitel or within 24 hours affe to the Funerel Dir completely filled in	Medical (	29a. Certifier 1 P Certify (Check only 2 Medical Medic	ring Physicien: To the be al Examiner: On the basi and manner	s of examination a stated.	ind/or investig	ation, in my op	oinion, death o	occurred at the time,	date an	d place, and due	to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certification	fier	1		29c. License	number	.00	29d. Da	ate signed (Month	Day, Year)	
	1		30. Name and address of person	ep 12	Wille 1	MD Brist	0	271	88	10	1 6/	26	
			30. Name and address of person	1c Talla	2 M	701ce	1-91	ace	Dund	d!	CXID	2/22	22
:	Sta Registr		31. Date filed (Month, Day, Yea	ar) 32. Reg. 2006	istrar's Signature	Spark.	j.		188 Dunda		<u></u>		

			1 - For State	State of Marylan		artment of H <i>rtificate of I</i>			_ <b>ZUU</b> D	32613
			1. Decedent's Name (First, Middle, Las.	0		rincate or i	Jean	2. Date of Death		3. Time of Death
	Physici /Medic		Virginia Chri	stina Simm	ons			October	14, 2006	5:17 pm M
i	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
			Franklin Square H			Roseda.			Baltimo	
	Funeral		5. Social Security Number 6. Se 218–12–4105	□M 2[XF	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)
hoder.	Director		Usual Residence of Decedent	79				1/25/19	2/ Mai	cyland
nyland	how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
e Ma	Ba-f s	cto	Maryland Baltimo	re Ch	ase					1 ☐ Yes 2 X No
with th	ror 2	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
death with the Maryland	78 23, Friund	Funeral Director	12507 Eastern Ave	NUE 12. Was Decedent Ever in U.	S 13	21220 Was Decedent of H	isnanic Origin? (Soe		U. S. A. 14. Race - Am	erican Indian
offer d	E PE	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No			ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black, Whi	
Surs a	Eval.	t by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	White
72 h	'natu	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece (Give	dent's Usual Occupa	ation during most of worki	ing 1	6b. Kind of Business	/Industry
d within	than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		"		Own Home	
D E	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		Honen	ianet	18. Mother's Name	(First, Middle, N		
lid be fil	rked ric ev	To B	John Dempsey				Ada Mag	y Leigh		
z sho	le ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
and:	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, I'm Medical Examinar must be notified at		Richard Simmons			Eastern			aryland 2°	
Ses 1	or of		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removal from State	emetery, crei	osition (Name of matory or other plac	10/		Oc. Location - City of	
ALLIMO mit. Pages	rtant		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	Luy	the same of the same	Crematory  2. Name and Addres		6 B	altimore,	Maryland
De d	Department of Healt Important: if item 2 any injury or other once.		Michael C. 2	Allon Sr.	F	Bruzdzinsk	ki Funera. Eastern A	l Home P. venue E	A ssex, Mary	land 21221
		ĺ	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	n. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition resulting in death)	a//	y nes	Fenzion				Onset and Death
	Medical kaminer		Tosaking in doubly	Due to (or as a conseq	uence of):	1 5				1905
	*	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq.	uence of).	ermisi >				-11/2
J, executed	ransit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.						
, š	ien ar urial-t	Ex	resulting in death) Last	Due to (or as a consequent	uence of):					
icate be e	physicien and s the burial-transit	edicai		d						
certif	nding Ise a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ncy				23d. Date of de	diverse
ECOLUS, P.O. DC	igned by the attending be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
) §	by the tache	hys	9 Unknown	9□ Unknown						
rds, r	gned be de	byF	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	inderlying cause give	en in Part I.		C-10	o the cause of death?
v requir	been si should	ed						1 🗆 Ye	s 2ENo 3□P	robably 4 Unknown
e law	has b je 2 sl	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
E He	ficete or, pag	e Co	25. Was case referred to medical					1□ Yes 2	X No 1 ☐ Ye	s 2□ No
VII de l'aician:	s certi	To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpatier	nt 3 DOA Othe	26. Place of Death	· · · · · · · · · · · · · · · · · · ·	nce 6 Other (Spe	acifu)
_ _ _ _ _ _ _ _ _ _ _ _	ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how		scriy/
VISION Attending	er: Af he fur	atio	2 ☐ Accident investigation		,		Yes 2 □No			
DIVISION OF VIEW Hospital or Attending Physician:	Direct in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti v)	reet, factory, office	1	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
spita	ners!		29a. Certifier 1X Certifying Phy	ysicien: To the best of my kno	wiedge, deat	h occurred at the tim	ne, date and place,	and due to the ca	use(s) and manner a	s stated.
To the Ho	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	one)	ines: On the basis of examina and manner stated.	tion and/or in					
2	To COL		29b. Signature and title of certifier	W/D Van R	lant 1	29c. License	17779	29	d. Date signed (Mon	(n, Day, Year)
	13		30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type,	Print) /	210	611	10/10/06	3
			Van &. Coms. 1.		6 holes	delpha l	Fd Dal	Amen,	WB 212	5/
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 6 2006	32. Registrar's Signa	Ture Court	E)				
		*	UP 1 P 5000	Jan State of	1					

DHMH 17 Rev 1/2001

			1 - For Amend item#1	State of Ma 9a, perinf, 686	ryland 10/20	Deni Cer	rtment of H	lealth and N Death	ental Hygi Re	ene g. N2 0 0	6 32615
	Physici		1. Decedent's Name (First, Middle Daphne	R. Salst	erg			udip	2. Date of Death Month OCTOBE	R 13, ž	3. Time of Death ear (2016 04: 2014
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number) ph Medical	Cent	er	4b. City, Town, or	Location of Death		4c. County of	
	Funeral Director		5. Social Security Number 219-44-6440	6. Sex 7. Age 1	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year 9	Birthplace (State or Foreign Maryland
	σ		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation	11			10d. Inside City Limits
	Maryla -f sho	tor	,	altimore	Too. Oity,	Тош					1 ☐ Yes 2 🕅 No
	or 28a	Funeral Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	at Country?
	eath w	eral [	1101 Hampton G	arth 12. Was Decedent B	Evoria II C	12.1	212		anife Van ar Na		S.A. American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be multied at once.	by Fune	11. Marital Status  1 □ Never Married 2√ Marr  3 □ Widowed 4 □ Divorced	Armed Forces? ied 1 ☐ Yes 2 ☑ N		Į li	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	spanic Origin? (Sp in, Mexican, Puerto Specify:	ecity tes or No-		White, etc. White
2-0	"natur	eted	15. Deceden (Specify only higher			(Give	lent's Usual Occupa kind of work done of OO NOT use retired	durina most of work	ring 1	6b. Kind of Busin	ness/Industry
212	d withir rithen	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)	_	surance	,		Health	
Maryland 21215-0036	should be filed and Mental Hyging imarked other umatic event,	To Be C	17. Father's Name (First, Middle, Steven		itas			18. Mother's Nam Sylv	e (First, Middle, M ia		elis
	nd 2 shoulth and N 27 is mai		19a. Informant's Name/Relations	erg-husband			g Address (Street a			City or Town, Sta 1D 2128	_
Baltimore,	Pages 1 and 2 ent of Health of: if Item 27 i		S. Bayne Salsberg  20a Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S	3 Removal from State	cem	etery, cren	sition (Name of natory or other place erv Corp	e) 10/1		oc. Location - Ci	ty or Town, State
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service		G. Da		Name and Addres			Funeral 21204	Home, Inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			G CANCE	R			Onset and Death
Н	Examiner		was a construction and a	PULMON			LI				
	इ. व.इ	luer	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):					
, , ,	ficate be executed physicien and is the burial-transit	I Examiner	that initiated events resulting in death) Last	cDue to (or as a	a consequer	nce of):					
68760,	flicate by physical properties of the properties	edical		d							
P.O. Box	The law requires that the death certifi tie has been signed by the attending i age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	,
	quires that in signed by uld be deta	ed by Ph	Part II. Other significant condition	ons contributing to death bu	ut not resulti	ng in the ur	nderlying cause give	en in Part I.			ute to the cause of death?
Division of Vital Records,	The law re ate has bee page 2 sho	Completed							24a. Was an autopsy perform	ed? dea	re autopsy findings available or to completion of cause of th?
Vita V	sician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital: 1 X Inpatie			Othe	ar .	h (Check only one		
J Of	ig Phy ter this neral d	on: To	1 Yes 2 No  27. Manner of Death	28a. Date of Injur	v 28	Outpatien  b. Time of Injury	28c. Injury Work	4 U Nursing Ho	ome 5 Residen 28d. Describe how		(Specify)
isior	ttendir death. ctor: Af the fur	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	pation and the same of lair			M 1 🗆 '	Yes 2 □No	28f Location /Stre	eat and Number	or Rural Route Number,
Ď	s after s after bi Dire	Certif	4 Homicide determ	building, etc	. (Specify)	o, iaiii, sii	set, factory, office		City or Town,		a rialarious ramber,
	To the Hospital or Attending Physician: The I within 24 burs after death.  To the Funeral Director: After this certificate ha Completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination	adge, death n and/or inv	restigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and mann se and place, and	or at etated. I due to the cause(s)
-	To the state of th	Σ	29b. Signature and title of certifie	P messo	. WA. (		29c. License		29	d. Date signed (/	Month, Day, Year)
	,2O		30. Name and address of person				D414	410		abber	13,2006.
	2		JOGINDER P M	EHTA, M.D.	761	01 0	SLER DR	IVE TOU	NSON, MAI	RYLAND	21204
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1		r's Signatur		SALL				

State of Maryland / Department of Health and Mental Hygiene 32616 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 12, 2006 **Physician** George John Stein 11:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth May 9, 1917 **Funeral** t**y**☐M 2□F 89 212-10-9776 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Madical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 415 Old Line Avenue 20724 or Itams 23a USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, Ire Madical Exercitations once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Engineer AAI Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John N. Stein Susan Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Old Line Avenue; Laurel, MD 20724 John J. Stein 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Joseph Church Cemetery 10/17/06 5 ☐ Other (Specify) Texas, MD 21. Signature of Fan and Service License 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terminal Aspiration /Medical Due to (or as a consequence of): Examiner Dysphagia 72 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine 7 The law requires that the death certificate be executed burial-transit Leukemia over 1 yr ettending physician and I for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical CHF 10 days 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ASCVD 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -3 runa 3200 40059310 06 30. Name and address of person who completed cause of death (Iz= 23a) (Type, Print) Bruce Neckritz, DO 14201 Laurel Park Drive #223 Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 Registrer

			1 = For State Registrar	State of Marylar		rtificate of			leg. No.	16	32617	!
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Raymond		Si	noth		2. Date of Dea Month	19ay 260	Year	3. Time of Death	1
	Examin Funeral Director	er	4a. Facility Name (If not institution, give such that her kins Boywer 5. Social Security Number 6. Sev. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	u Medical Con	last birthday)	4b. City, Town, Balt If Under 1 Year Months Days		8. Date of Birt	4c. County n, Year) 1949		lace (State or Foreig	ın
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits	s
	a-f sh	ctor	MD Baltimor	e I	Essex						1 ☐ Yes 2 🔀 No	)
	with th	Director	10e. Street and Number	1		10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?	
	tems 23	Funerai	THE MANUEL STATES	12. Was Decedent Ever in L Armed Forces?	I.S. 13.	21221 Was Decedent of If Yes, specify Cul	Hispanic Origin? (S oan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	USA 14. Rac Blac	e - Americ k, White,	an Indian, etc.	
9036	ours afte	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: 71-	73	1 ☐ Yes 2 🛣 No	Specify:		Specify	wh:	te	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Medical Exant at must be rediffed at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	_	a during most of wo ad)	rking	16b. Kind of Bu		•	
d 21	Hygier Hygier Sther tl		17. Father's Name (First, Middle, Last)		Recom	pression		me (First, Middle,	Tumble		ps	
/lan	should be and Mental marked o	To Be	Henry Eugene	Smith	,		Helen	May	Kahler			
Man	12 sho h and I 7 is ma traume		19a. Informant's Name/Relationship (Ty Darlene Smith - wi			-	tand Number or Ri nch Place				Code) 21221	
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla		Date Date	20c. Location -			+
Baltimore,	T P E E		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	esapeal	ke Crema	tory 10/1		Beltsv	ille	, MD	
Balt	permit. Pages 1 al Department of Hea Important: if Item eny Injury or othe		21. Signature of Funeral Service License		986 8	AFA, Ste 717 Gree	ess of Facility Phen D. I n Pasture	ohrmann, s Drive,	PA Towson	, MD	21286	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			-				Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	Cancer of):	to the	liver, 1	colon, an	d paner	ea5	1 year	
<b>60</b> , <b>6</b>	ficate be executed by physician and strength burial-transit control of the purial-transit contro	ai Examîner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	quence of):	ms Cell	Cercinome	e of 4h	e Tongo	16 1	year, 2 ma	21
.O. Box 68760,	Attanding Physicien: The law requires that the death certificate or death.  r death.  ector: After this certificete has been signed by the attending phys by the funeral director. page 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome ol pregn 1  Live birth 2 Fet 4 Pregnant at time of 6	al death 3	Ectopic pregnand Other (specify)	cy		23d. Dat Mo	e of delive	ery Day Year	
rds, P.	quires that n signed b uld be deta		Part II. Other significent conditions con	ntributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.			nbute to th	ne cause of death?	n
Division of Vital Records,	The law ree ete has bee page 2 sho	Completed						24a. Was autop perfo 1  Yes	rned?	Were auto prior to con death?	psy findings availabl mpletion of cause ol 2 \( \text{No} \)	е
Vita Vita	ician: certific rector.	Be	25. Was case referred to medical examiner?	lospital:			hor	ath (Check only o				
n of	ng Phys fter this meral di	on: To	1 ☐ Yes 2 No ☐ 27. Manner ol Death Statural 5 ☐ Pending	lospital: 12 Inpatient 2 C 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Inju	iry at ork?	Home 5 ☐ Resident 28d. Describe h	ow injury occurr		y)	
Oivisio	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide Gould not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, larm, str		]Yes 2 □No	281. Location (S City or Tox		er or Rura	il Route Number,	
	To the Hospitel or within 24 hours after To the Funeral Dirt completely filled in I	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	ime, date and place opinion, death occi	e, and due to the curred at the time,	cause(s) and ma date and place,	inner as s and due to	tated. the cause(s)	
	Tathe within 2 To the complet	Σ	29b. Signature and title ol certifier	0. 1		29c. Licer	se number		29d. Date signed	d (Month,	Day, Year)	
	2+1		30. Name and o ess of person who ex	MC, MD impleted cause of death (Ite	m 23a) (Type.	Print)	SOU 1		ktober	, 11	, 2006	
	2'		Dr. Crystal C	lark 494	to E	ustern )	trenue,	Baltimo	ne, M	D 2	1224	7
	Sta	te	31. Date filed (Month) Day, Year)	32. Registrar's Sign	aprite	and I	Ť					·

		1 - For Amend Item 19b	e of Maryland	d / Departi <b>G860</b> e10	ment of Hea /18/06dhb	ith and M ath	lental Hyg	iene g. N2 006	32618
		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Yeer	3. Time of Death
Physic /Med		REBA			SUROSI	<b>(Y</b>	october	11' 2006	1 03 AM
Exami		4a. Facility Name (If not institution, give street an			. City, Town, or Loc	P	4	4c. County of Dea	th
		Sinai Hospital o	7-0		Balt WW	Jnder 24 Hrs.	7	N/A	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X  Usual Residence of Decedent	7. Age (In yrs. I			ours Min.	8. Date of Birth (Month, Day, 06/01/1	922 9. Bit C	thplace (State or Foreign ountry) MD
land ow		10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow r must be notified at	tor	MD N/A	B	ALTIMORE	•				1 ☐ Yes 2 ☐ No
n the	Funeral Director	10e. Street and Number			Of. Zip Code		10	g. Citizen of What C	ountry?
th wit	alD	6727 GREENSPRING AVEN	NUE		21209	)		U.S.	Α.
dea a	iner	Arme	Decedent Ever in U. ed Forces?	S. 13. Was	Decedent of Hispar s, specify Cuban, M	nic Origin? (Sp exican, Puerto	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
o afte	by Fu	IT YA	Yes 2∭X No s, G <u>i</u> ve			pecify:		Specify:	
hours a Exam		3 Widowed 4 □ Divorced Year  15. Decedent's Education	r or Dates:	16a Decedent	s Usual Occupation			16b. Kind of Business	WHITE
d Z IZ 13-0050 filed within 72 hours atter Hygiene. other then "netural", or the ent. If a Medical Examina	Completed	(Specify only highest grade comple		(Give kind	s Osual Occupation f of work done during NOT use retired)	g most of work	ing	160. Kind of business	rindustry
iene iene iber	- Julo	Elementary/Secondary (0-12) Collection Colle	ege (1-4or 5+)	HOMEMA	KER			OWN HON	IE
IL X IX IX—IX—IXXXIIIIIIIIIIIIIIIIIIIIII	60	17. Father's Name (First, Middle, Last)				Mother's Name	e (First, Middle, A		
Janua Jid be fili Jental H rked oth	To B	ISRAEL		WOOLF	I	:DA			SACKS
DESIGNATION FOR WHAT YIELD ALL INCOMES PROMISE PROMISE A PARTY PROMISE. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "netural", or items 23a or 28a-1 show any highry or other traumatic event. Its Medical Examinar must be motified at 2008.		19a. Informant's Name/Relationship (Type, Print CONNIE RUSKIN / DAUGH		19b. Mailing A	ddress (Street and I ARALA ROA			City or Town, State, MD 21208	Zip Code)
S 1 ag	10.3	20a. Method of Disposition	20b. P	lace of Disposition	n (Name of			20c. Location - City or	Town, State
Dallillor permit. Pages Department of P Important: If Ite any Injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)			NDER VERE	IN 10/1	3/2006	ROSEDALE,	MD
mit. partm porta y Inju		21. Signature of Funeral Service Licensee		22. Na	ame and Address of	Facility SO	LEVINS	ON & BROS.	INC
Dermi Depa Impo		Rose de		890	O REISTER			IKESVILLE.	
Physician		Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death on each line. Pheu mo	,	ne mode of dying, su	ich as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	ue to (or as a consequ	uence of):					
	Iner	cause. Enter Underlying	ipeanon a se to) of ei	ienca of):				7	
be executed iclen end burial-transit	Examiner	that initiated events c.	ue to (or as a consequ	uence of):					
ate be e hysiclen	Ical	d							
he corrus, F.O. BOX 00/00,  a law requires that the death certificate be executed has been signed by the ettending physicien end be 2 should be detached for use as the buriat-transit	ysician/Med	in the past 12 months?	s, outcome of pregna Live birth 2 ☐ Fetal Pregnant at time of de Unknown	death 3 Ec	opic pregnancy her (specify)			23d. Date of de Month	livery Day Year
The law requires that the death The law sequires that the death ate has been signed by the etter page 2 should be detached for u	d by Physi	Part II. Other significant conditions contributing  Atticl Fibri Lotion,	to death but not resu Right in t		tying cause given in	Part I.		acco use contribute t	o the cause of death?
v requ	ete	Colonory Arkry Dise	ese, they		26 Heart	the.	24a. Was a	24h Wara a	utopsy findings available
II necords, The law requires tele has been signe, page 2 should be	Completed	widism	~~) '\][	000190170	, /wj/~	J	autops: perform	y prior to	completion of cause of
vital iclan: T certificet ector, pa	Be	25. Was case referred to medical examiner?  Hospital:			Othor		h (Check only on		
Phys rthis ral dir	lon: To	27. Manner of Death 28a.  1. Natural 5 ☐ Pending	1 Inpatient 2 Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			nce 6 Other (Spe w injury occurred	icify)
JIVISION or Attending effer death. Director: Afte	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At ho		M 1 ☐ Yes	20110	28f. Location (St.	reet and Number or F	ural Route Number
tal or A s efter el Direct	Certification:	4 Homicide	building, etc. (Specif)	/)	410,000		City or Town	, State)	
ne Hospl 24 hour Ne Funar Jetely fills	edical	29a. Certifier (Check only one)  2 ☐ Medical Examiner: On and	To the best of my kno- the basis of examinal manner stated.	wledge, death oc tion and/or invest	curred at the time, d gation, in my opinio	ate and place, n, death occur	and due to the cared at the time, da	luse(s) and manner a ate and place, and du	s stated. e to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier			29c. License nur			d. Date signed (Mon	
		> pBredersheete	Mb		RES -	- 000	0	ctober 11	, 2006
,0		30. Name an oddress of person who completed		23a) (Type, Prir	(1)	400	n4 .a -	ctober 11 timore	
1		GITANA BRADAUSK91			irile Mos	4 1616	1300	n word	
St Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					

A, known as

Raymond Scott Vickery

#### Please Type or Print in Black Indelible Ink

,		
State of Maryland /	Department of Health	and Mental Hygiene

		1- For State Registrar	Certific	cate of D	eath		Re	g. No. 200	32619
Physici		1. Decedent's Name (First, Middle, Last)				-	Date of Death     Month	Day Year	3. Time of Death 1552 hrs
Medical Exam	iner	Raymond Scott Vicker  4a. Facility Name (if not institution, give street and number	_	4b (	City, Town, or Lo	ocation of D	October 4,	2006 4c. County of Death	
		13901 Wisteria Drive	,		ermantown			Montgomery	
Funeral	1 2	5. Social Security Number 6. Sex 7. A	ge (In yrs. last b	_	Under 1 Year	If Under 24		h (MM/DD/YYYY) 9. Biri Foreig	
Director		262-45-3507 1XM 2_F	47	Yrs.	Months Days	Hours	MAY 12	1959	untry) FL
ηλ		Usual Residence of Decedent  10a. State 10b. County	10c City, Tow	n or Location					10d Inside City Limits
d how an		MD Montgomery		antown					1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number	J OCE III		f. Zip Code		10	g. Citizen of What Cour	^ ^
th the Maryland 23a or 28a-f sho notified at once.		20039 Placid Lake Terrace	2		20874			USA	
h with ems 23 t be no	Funeral	11. Marital Status  1 Never Married 2 Married Armed Force:					( Specify Yes or No- erto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
er deat , or ito	Fu	i live ver ivialitied 2   Ivialitied	X No				,,		
ırs aftı tural" ımine	d by	15. Decedent's Education (Specify only highest grade co	mpleted) 16a		s 2 X No Isual Occupation		of work done	Specify: Whi	
5 72 ho in "na cal Ex	mpleted	Elementary/Secondary (0-12) College (1-4 o			of working life. D	OO NOT use	retired)		
5-0036 led within 72 Hygiene other than '	omp	11	A	rtist				Art	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last)  Leonard Hunter Vicker	·V		18	Ruby	ame (First, Middle, M Louise	LaRue	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mertal Hygerer 17 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	10 B	19a Informant's Name/Relationship (Type, Print )	11	9b. Mailing Ad	dress (Street a	,		ber, City or Town, State	, Zıp Code)
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		Valerie A. Schnell - siste						FL 33321	
ore, slan of Hea If iten		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from 5		of Disposition atory or other p	(Name of ceme place)	etery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify:	Chesa	apeake	Cremato	ry   10	0/14/2006	Beltsvill	e, MD
Balt permit. Departi Impori		21. Signature of Funeral Service Licensee	M0098	CAFA	and Address of Steph	of Facility nen D.	Lohrmann res Drive	, PA	
Physician		23a. Part I. Enter the disease, or complications that cause		not enter the m	Green lode of dying, su	Pastu uch as cardi	I <u>res Drive</u> ac or respiratory arre	TOWSON, I st, shock, or heart	D 21286 Approximate Interval
/Medical Examiner	8	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertense	sive cardi	iovascula	r disease	е			Between Onset and Death
Cxammor		or condition resulting in death)  Due to (or as a con	sequence of):						
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):						
	amin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a con	sequence of):						-
executed in and	ŭ	d.	, ,						
	/Medical	X UNPENDED AMENDED #23a,	27, perME, g	3861 <b>,</b> 11/2	2/06 TT				
8760, ificate be er ig physicial	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	ome of pregnanc	у	eath 3	Ectopic pre	egnancy	23d Date of delivery Month	ay Year
Box 68 are death certification the attending red for use as t	sician	4 Pregnant	at time of death		(Specify)		· 3······)		,
D. Bc t the dea by the a	Phys	Part II. Other significant conditions contributing to dea	th but not regulti	ing in the unde	rlying course any	on in Part I	23e Did to	bacco use contribute to	the cause of death?
P.O.	by	Solution of the second	arr but not rooditi	ing in the dide	nymg oddso giv	CITITITI GILL.	1 Yes		ably 4 🗸 Unknown
ords, P.C. w requires that as been signed to should be deta	Completed						24a. Was a		topsy findings available
acol ne law te has ge 2 sl	m d						autops perform 1 ✓ Yes 2	med? death?	ompletion of cause of
fital Rec sician: The L is certificate P irector, page	اده	25. Was case referred to medical			26 Place o	of Death (Che	eck only one)	10 10	3 2 10
Vita hysicia this ce	O B	I V Tes 2 NO	ient 2 ER/	Outpatient 3	DOA O	other Nu	ursing Home 5	Residence 6 🗸 Other	Scene
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be 1s after death.  The Invector: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	.:.   :::	27. Manner of Death  1 X Natural 5 Pending 28a. Date of In (Month, Day)	jury 28b ,Year)	. Time of Injury		at Work? es 2 No		ow injury occurred	
Sio Ntten deatl ctor:	cati	2 Accident Investigation 28e Place of	Injury - At home,	farm street fa				treet and Number or Ru	ral Route Number City
Division of the hours after dumeral Direct y filled in by	Certification	Suicide 6 Could not be determined (Specify)	,,	,,		g, e.e.	or Town, St		an reason training only
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of							
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	one) 2 Medical Examiner: On the basis of example and manner states	amination and/or	investigation,			red at the time, date a		
_ V.	Σ	29b. Signature and title of certifier			29c. License			29d Date signed (Mor October 5, 2006	nth, Day, Year)
A X		Musser Blasse U. M. 30. Name and address of person who completed cause of	death (Item 22a)		0.0.1			30.0001 3, 2000	
10/0		Melissa Brassell, MD Assistant Medica			n Street, Ba	iltimore, N	MD 21201		
	tate	31. Date filed (Month, Day Year) 6 2006 32. Regist	ar's Signature	le An					
Regis	trar	MAI A V EUVY July	algebrasia spira	And for the	THE V				

#### Please Type or Print in Black Indelible Ink

nsta	nce Wils	on	1- For State	tate of Maryla		artment of <i>rtificate of</i>			Menta	al Hy		eg. No.	nn	5 3262
	Physici	ian/	an/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year October 13, 2006								3. Time of Death			
edica	al Exami	ineı	TOTAL CONTROL TITLE OF T									3, 2006		1717 hrs
			4a Facility Name (if not instituti Johns Hopkins Hosp	=	mber)	4	b. City, To Baltim		ocation of	Death		4c. Cou	nty of Death	1
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under		If Under		8. Date of Bir	th (MM/DD/Y		thplace (State or Foreign
	Director		unknown	1 M 2 X F		76 Yrs.	Months	Days	Hours	Min.	09/12	/1930		untry) <b>ermuda</b>
	Ą	]	Usual Residence of Decedent  10a. State 10b. County		Idoa Citu	Town as Location								Land In-life City I make
	ow any		Rozmida	Hamilton	Toe, City,	Town or Location	on iknown							10d. Inside City Limits  1 X Yes 2 No
	ryland a-f sh it onc	흉	10e. Street and Number	nain Iton		- Cir	10f. Zip (	Code			11	0g. Citizen o	f What Cou	
	ith the Maryland  23a or 28a-f show notified at once.	Directo	Cloverdale North D	evon Shire					ıknown				muda	
	with a	ral	11 Marital Status	Access of Co	edent Ever in U						cify Yes or No	- 14. R	ace - Amer	ican Indian, Black,
	or ite	Funeral	1 Never Married 2 N	Married Armed Fo	2 X No		es, specify	-		Puerto R	ican, etc.)		Vhite, etc.	
	2 hours after "natural", Examiner	۾	3 Widowed 4 D	vorced If Yes, Give Yea or Dates:			Yes 2				al. al	Spec 16b. Kind o	ify: Blac	
	2 hour	Completed	Elementary/Secondary (0-12			16a. Decedent during mo	ost of work					100. Kind 0	i business/	inqustry
5-0036	ed within 72 tygiene. other than the Medical	I du	unknown	unkno	wn	Exe	cutive	Hous	ekeen	or		Pink F	Beach H	otol
5-0	iled w Hygie I other the N						000270				irst, Middle, I	Maiden Surna	ame)	mer
2121	ld be f fental narked event,	Be C	George Woolridge  19a. Informant's Name/Relation	ship (Type Print )		10h Mailing	Address	(Street	and Marak	Li	11ian Ha	nley	T 01-1-	7-0-1-)
MD 2	Pages I and 2 should be filed within 72 hours after death waren of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be or other traumatic event, the Medical Examiner must be	ပ	Elliston C.V. Jim		Brother						muda F-	-	rown, State	; Zip Code)
e,	l and Health item r trau		20a. Method of Disposition		20b.	Place of Disposi crematory or oth	ition (Name				Date		on - City or	Town, State
υOr	Pages ent of nt; If		1 Burial 2 Crematic		om State	Bermu				10/1	7/2006	Hami1	ton, B	ermuda
Baltimore,	permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Department of Health and Mental Hygiens in "matural", or items 23a or 28a-f she Important; If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service licensee   22. Name and Address of Facility   Wylie Funeral Home, P.A.											
			Shuela	Jones	11 111					et; B	altimore	, MD 2	1217	
	nysician Medical	ľ	23a. Part I. Enter the disease, of failure. List only one caus	e on each line.				ayıng, sı	uch as car	diac or r	espiratory arr	est, snock, or	neart	Approximate Interval Between Onset and Death
<b>F</b> 2	kaminer		Immediate Cause (Final diseas or condition resulting in death)		consequence of		cinoma				-	_		Dod
		<u>.</u>	Sequentially list conditions,	b.									_	
		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		consequence of	π).								
4	ted J unsit	Examine	events resulting in death) Last	Due to (or as a	consequence o	of):								
1);	ate be executed hysician and e burial - transit	Medical	UNPENDED	AMENDED									-:	
760,	icate b g physi the bu		IF FEMALE: 23b. Was decedent pregnant in	tho —	outcome of preg				7				e of delivery	
Box 687	leath certificate e attending phy for use as the b	cian	past 12 months?	I Tive p	irth ant at time of de	a deba	tal death ner (S <i>peci</i> i		Ectopic p	pregnand	cy	Mont	h [	Day Year
Bo	e deatl the att ted for	Physician/		9 Unkno										
P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 but out after death. The law requires that the but of the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ğ	Part II. Other significant cond	itions contributing to	death but not r	esulting in the u	nderlying o	cause giv	en in Part	I.		bacco use co 2 🗸 No		the cause of death?  pably 4 Unknown
rds,	w requir is been s should	letec									24a. Was autop			topsy findings available completion of cause of
of Vital Records, P.	he law ate has age 2 sl	Completed					_				perfo	med? 2 ✔ No	death?	
ᆱ	cian: The certificate ector. page	Be C	25. Was case referred to medic examiner?				26		f Death (C	heck on	42.13			
Ξ	Physic r this c al dire	ToE	1 ✓ Yes 2 No			ER/Outpatient		<i>"</i> \	based.			Residence		
o uc	ending Ph ath r: After 1 he funeral			28a. Date Oct 3, 2	of Injury Day, Year) 006	28b. Time of Ir 0000 hrs	njury 128		at Work? s 2 ✔ N	Is	8d. Describe I ubject fell	now injury oc	curred	
Division	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification	3 Suicide 6 Co	ald not be	e of Injury - At h	ome, farm, stree	t, factory,	office bui	lding, etc.	2			ımber or Ru	ral Route Number, City
Ö	spital hours a neral l	Cert	4 Homicide det		Single Fan						or Town, S E. Pleasa	nt St., Bal		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only   Certifying	Physician: To the bes aminer: On the basis of	of examination a									
	To wii. To	Mec	29b. Signature and title/of certif	ier / manner	ared.		29c.	License	number			29d. Date s	signed (Moi	nth, Day, Year)
			SNOVA	m //	VI			O.C.M	.E.			October	15, 2006	6
	3		30. Name and address of person Susan Hogan MD.	n who completed caus Assistant Medic			n Street	Raltin	nore Mi	D 212	)1		_	
	S	tate	01 5 1 6 1 1 1 1 1 1 1 1		gistrar's Signati		Oticet	, Daitill	TOTE, IVII	U Z 1 Z 1	-			
	5	16:16:	31. Date filed (Worter, Day, rear	02.1	giotiai a digitati	ui C								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certif	icate of i	Death			Reg No.	20	06 321	62
Physici Medical Exami		Decedent's Name (First, Midd		rald Rob	ert We	11s		2. Date of De Month October	Day	Year	3. Time of Death 2104 hrs	1
		4a. Facility Name (if not institution 18334 Streamside DF		nber)	45	. City, Town, or L Gaithersburg		eath		County of Dontgomer		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last I	birthday)	If Under 1 Year			Birth (MM/DI		Birthplace (State or	
Director		579-98-5359	1 <b>X</b> M 2 F		<b>39</b> Yrs.	Months Days	Hours	Aug.	17,	1967	oreign Country) <b>Illin</b>	ois
		Usual Residence of Decedent										
w any		10a. State 10b. County		10c. City, Tov	wn or Location	n					10d. Inside City I	
Maryland 28a-f show d at once.	ē	MD Montg	omery	Gaith	ersbur						1 Yes 2	<b>X</b> No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code				n of What (	Country?	
ith the 23a continue	ョ	18334 Streams  11. Marital Status		# 103 dent Ever in U.S.	12 1/100	20879	ania Osiaia	Specify Yes or N	U.S.		District Plants	
eath w items	Funeral		arried Armed For	ces?		s, specify Cuban,			10-	White, et	merican Indian, Black, c.	
ifter d	by Ft	3 Widowed 4 Div	1 X Yes vorced If Yes, Give Year or Dates:	2 No	1 1	es 2 X No	specify:		S	pecify: W	nite	
iours a	ஓ	15. Decedent's Education (Spe		completed) 16		Usual Occupation					ess/Industry	
36 n 72 h nan "r	Completed	Elementary/Secondary (0-12)	- 1	4 or 5+)				retired)		ident		
15-003 filed withi Hygiene d other th	E	17. Father's Name (First, Middle	2			Carpente		me (First, Middle		struct	tion	- 17
21215-0036  Mottal Hygiene marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified a t once	BeC	Robert Matthe						Slumensch		umame)		
e a de la		19a. Informant's Name/Relations			19b. Mailing A			or Rural Route Nu		or Town, S	tate, Zip Code)	
MD id 2 sho lith and m 27 is aumati	1	Joyce Wells-M	other					race, Ha	aymarl	ket, V	7A 20169	
le, slar fHea ffiter er tr		20a. Method of Disposition  1 Burial 2 T Cremation	n 3 Removal from		e of Disposition of the opolitical corrections of the opolitical c	on (Name of cem r place)	etery,	Date	20c. Lo	cation - City	y or Town, State	
Page Page ment o		4 Donaylon 5 Other S		Metr	opolita atory	an	10	-12-2006	A1	exandı	ria, VA	
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Service	Licensee	_	22. Na	me and Address	of Facility	Pierce-l	Price	Fune	ral Home	
	2.7	23a. ar I Enter the disease, or	complications that car	ised the death. Do				et, Mana				
Physician /Medical		failure. List only one cause	on each line.		not enter the	mode or dying, s	deri as cardia	c or respiratory a	rrest, snock	r, or neart	Approximate Int Between Onsel Death	
Examiner	٦	mmediate Cause (Final disease or condition resulting in death)	Due to (or as a								Death	
1		Sequentially list conditions,	b									
	Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a d	consequence of):								
1 -	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):								
executed an and all - transi			d									
- o - 5 E	n/Medical	UNPENDED	AMENDED									
8760, tificate being physicias the buri	Ě	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, ou	utcome of pregnant	-	death 3	Ectopic preg	mancy		Date of deli	very Day Year	_
	iż.	past 12 months?	4 Pregna	nt at time of death	2 Fetal	(Specify)		grianicy	"	OTILIT	Day real	
Box 6 he death cel the attend	Physicia		known 9 Unknov									
ords, P.O. I	b P	Part II. Other significant condit	ions contributing to	death but not result	ting in the und	derlying cause giv	ven in Part I.				to the cause of death	
S, F	eg							-			Probably 4 Unkno	
COFC law re has be	흹							_ 24a. Was			autopsy findings ava to completion of cause	
Rec The l icate l	Completed								2 No	1 🗸		io
Vital Rec hysician: The this certificate	æ	25. Was case referred to medica examiner?	Heaviel				of Death (Che					=
of Vital Records, R. Physician: The law requir wher this certificate has been s meral director, page 2 should	ို	1 Yes 2 No 27 Manner of Death	28a. Date o		Outpatient  b. Time of Inju			sing Home 5		e 6 🗸 O	ther Scene	
_ = = \~ <del>=</del>	Certification:	1 Natural 5 Pend	ding FOUND:	Day,Year) FC	DUND:		es 2 V No	Subject she		occurred		
Division tal or Attendi rs after death al Director: A	fica		d not be Oct 8, 20	of Injury - At home	04 hrs , farm, street,	factory, office but	ilding, etc.			Number or	Rural Route Number,	City
Divisi pital or At ours after d eral Direct filled in by	둜	4 Homicide deter		Multi-Family A	Apt.			or Town, 18334 Stre	State) amside	Drive, Ga	aithersburg, MD	- 1
e Hos 24 hc e Fun etely t		29a. Certifier 1 Certifying Pt	hysician: To the best	of my knowledge, o	death occurre	d at the time, date	e and place, a	and due to the cau	ıse(s) and ı	manner as s	started	
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner:On the basis of and manner sta	examination and/o	r investigation			d at the time, date				
	Σ	29b. Signature and title of certifie	er			29c. License			1 _		Month, Day, Year)	
		Yamek Jou	may, me	)		O.C.M	I. <b>L</b> .		Octob	er 9, 200	J6 	
5		30. Name and address of person Pamela E. Southall, M	•	of death (Item 23a ledical Examir	,	Penn Street,	Baltimore	, MD 21201				
	333	31. Date filed (Month, Day, Year)		istrar's Signature	All and a state	a		-				
Regist	rar	0CT 1 6 2U	106	A B.	Grand .							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 0 0 6

			1 = State Registrar	Ce	rtificate of Death	Reg. I	£000	32622
	Physici	Ģ an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	DavYear	3. Time of Death
	/Media		Eleanor Wulsin				13, 2006	3:00 a м
	Examir	ier	4a. Facility Name (If not institution, give street an Pickersgill		4b. City, Town, or Location of Death Towson		Baltimore	
	Funeral Director		5. Social Security Number 214-12-8065 6. Sex	7. Age (In yrs. last birthday 89 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye, Feb. 4,	Cou	place (State or Foreign intry) ~yland
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	e Mary Ba-f sh etified a	Director	Md. Baltimore	Towson				1 □ Yes 2 🗖 No
	ith with th 23a or 21 ust be no	ral Dire	615 Chestnut Ave.		10f. Zip Code 21204	10g.	Citizen of What Cou	intry? SA
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. ad Forces? yes 2 XNo s, Give or Dates:	Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
ה ה	72 ho 'natur dical	eted	15. Decedent's Education (Specify only highest grade comple	ted) 16a. Dece	edent's Usual Occupation a kind of work done during most of work	16b.	. Kind of Business/Ir	ndustry
7	e filed within 7 al Hygiene. other than "r vent, the Med	Completed		(de (1-40r5+)	e kind of work done during most of work DO NOT use retired) oyment Counselor		tate of Oh	nio
70	filed Hygid Sther ent, th		17. Father's Name (First, Middle, Last)	T Linp1		e (First, Middle, Maid		.,,
yland	uld be Mental Irked o	To Be	Clarence Eugene Tubma	n	Jeanne	Power		
Mar	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medions.		19a. Informant's Name/Relationship (Type. Print, Mr. Lucien Wulsin, Jr.		ing Address (Street and Number or Rui Wilshire Blvd. #4			,
<u>ရ</u>	Healt tem 2		20a. Method of Disposition	<u> </u>			Location - City or T	
altimol	Pages ient of nt; If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f	rom state		.6-06	Towson, N	Md.
ā	mit.		21. Signature of Fune all Savice Licentee		2. Name and Address of Facility Ruck Towson Fune		Inc.	
מ	B a E B		ME		1050 York Rd. 10	owson, Ma.		
	Physician /Medical		23a. Pan 1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do not en on each line.	cordianter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner			e to (or as a consequence of):	/			
	n A	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of):				
	certificate be executed ding physician and se as the burial frost.	Examiner	triat iritiated events					
Š.	be exician go		Du	e to (or as a consequence of):				
00/00	ficate physi s the	/Medical	d					
		Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year
Ţ.	s that ned by deta		Part II. Other significant conditions contributing	to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacc	o use contribute to t	the cause of death?
ecords,	equires en sig ould be	ed by				1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
ם וו	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for u	Completed				24a. Was an autcpsy performed′	prior to co death?	opsy findings available ompletion of cause of
VII	sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:		0.1	h (Check only one)		
5	J Phys er this eral di	1: To	27. Manner of Death 28a. D	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time of	111 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how in		(b) hospio
NISIO	inding ath. ir: Afte	atior	2 Accident investigation	Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
2 2	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. F	Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	ne Hospi n 24 hour he Funer oletely fill:	Medical (	(Check only /2 Medical Examiner: On t	o the best of my knowledge, dea the basis of examination and/or in manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as s and place, and due t	stated. to the cause(s)
	To the Complete Compl	Ň	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
	j		· youan	Requestre	D28303	00	Mober 11	1 2006
	6		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Charles St BA	cours a	26200	
			William Charles and	, 000 ,	20 30 -9 31 18/1	21 2 -	, - 000	7

DHMH 17 Rev 1/2001

Registrar

OCT 1 6 2006

1 - For		State of Maryland / D	epartment of Hea		ygiene Reg. 2006	32623
	ent's Name (First, Middle, Last)			2. Date of D	Death	3. Time of Death
Physician /Medical	JOAN Ve y Name (If not institution, give st	WINEKE	4b. City, Town, or Lo	Month OCT	15 2006 4c. County of Death	2:00 AM
FRA	NKLIN WOODS	HEALTH CARE	= BALTIMO	DRE	BALTIM	
Funeral 5. Social 214	Security Number 6. Sex 1 4429	7. Age (In yrs. last birth			Day, Year) Counti	ace (State or Foreign ry) -RYLANO
0		10c. City, Town	or Location		10	d. Inside City Limits
ms 23e or 28a-1 show rmust be notified at remaining at 10e Stree Director	BALTIM (	DRE BALT.	MORE 10f, Zip Code		10g. Citizen of What Country	1 ☐ Yes 2 ☐ No
rith with		N SQUARE D	R 2123	1	USA	,
	al Status 12 ever Married 2 Married  idowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1		anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - America Black, White, e Specify: With	tc.
72 hc	15. Decedent's Educi (Specify only highest grade	completed) (	Decedent's Usual Occupation Give kind of work done during life. DO NOT use retired)		16b. Kind of Business/Indu	•
d within displayed.	ntary/Secondary (0-12)	College (1-4or 5+)	LERICAL		CLEANI	NG
Be fill Hy Lather Hy Lathe	r's Name (First, Middle, Last)	UMBRUN	18	RUTH M		
2 should and M 19a' luto	rmant's Name/Relationship (Type	9, Print) 19b. I		Number or Rural Route Num	ber, City or Town, State, Zip C	
_ E E E E	20L WOLFOR	20b. Place of I	Disposition (Name of	Date	mone my 21  20c. Location - City or Tow	n, State
Pages neutri filt in various 10 10 10 10 10 10 10 10 10 10 10 10 10	Burial 2. <b>™</b> Cremation 3.□Re Donation 5.□Other <i>(Specify)</i>	moval from State	L Chenation, I	ne 10/18/2006	HAMPSTERN	, mo
Baltimore permit. Pages 1- Dapardment of He Important: If itan any injury or oth once.  70 West 1   12 Sidu.	ature of Funeral Service Licensee		22. Name and Address of	of Facility JNZUMB	ELDERS BURG M	60
sho	ck, or heart failure. List only one	ations that caused the death. Do no cause on each line.	ot enter the mode of dying, s	such as cardiac or respiratory		Approximate Interval Between Onset and Death
Physician disease	te Cause (Finat or condition in death) a.	Due to (or as a consequence of				
Examiner Sequent	ally list conditions, b.	End St Due to (or as a consequence of	age Do	ementia		
if any, le cause, in cause, Cause (Cause) (I that initiar resulting	ading to immediate inter Underlying Disease or injury ted events c.		,			
burria ai	in death) Last	Due to (or as a consequence of	):	1		
ω ≠ ± σ	LE:	c. If yes, outcome of pregnancy				
O. B. De death the attention of the death of	s decedent pregnant se past 12 months? Yes 2 Ano Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
be detail. O	her significant conditions cont	ributing to death but not resulting in	the underlying cause given in		d tobacco use contribute to the Yes 2 □ No 3 □ Proba	l -
Rec				24a. Wa aut per 1	opsy prior to com formed? death?	sy findings available pletion of cause of
Vital Sician: 1 Sician: 7	case referred to medical iner?			6. Place of Death (Check only	(one)	
the side of the si	es 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tii			sidence 6 Other (Specify) how injury occurred	
Vision of Attending F attending F attending F attending F attending to the funer of	latural 5 Pending Accident investigation		ury Work?	250. Describe	s now injury occurred	
Division c tal or Attending P tal or Attending P is after death. al Director: After t ed in by the funera Certification:	Guicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		(Street and Number or Rural own, State)	Route Number,
idso 29a. Cer	eck only 2 Medical Exemine	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, for investigation, in my opinion	date and place, and due to the on, death occurred at the time	e cause(s) and manner as sta e, date and place, and due to	ted. the cause(s)
To the Ho within 24 To the Fo completel Medic	nature and title of certifier		29c. License nu		29d. Date signed (Month, D	ay, Year)
	1100	MD		3462	10/17/06	
30. Name		npleted cause of death (Item 23a) (T	ype, Print) OPKWO3 d	Road Co	len Burnie r	NB 21061
	filed (Month, Day, Year) QCT 1 6 200	32. Registrar's Signature	Speck)			

State of Maryland / Department of Health and Mental Hygien 2006

32624 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:38 A<sub>M</sub> 9 26 2006 ANDERSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F 578-46-7784 70 Yrs Director 11/18/1935 WASHINGTON, D.C Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No PRINCE GEORGE'S SUITLAND Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with or items 23a or 20746 3754 WILKINSON DRIVE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No λq 3 → Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPT. OF ENERGY at Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 is marked other th any Injury or other traumatic event, this once. MAIL CLERK FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARENCE JACKSON RUTH JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH WILCOX - DAUGHTER 3967 CLAY PLACE N.E. WASHINGTON, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 10/1/2006 BRENTWOOD, MARYLAND 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 21. Signature of Fun val Se per Licensee 3401 BLADENSBURG ROAD., BRENTWOOD, MD. 20722 why 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 LUNG CARCINOMA META STATIC 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2√ No 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 RVOutpatient Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Injury within 24 hours after death. To the Funerel Director: Al completely filled in by the fu 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 26,2006 D40324 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 7563 SURRATTS ROAD, CLINTON, MARYLYTUD JODRIE, MD TERRY Registrar's Signature... 31. Date filed (Month, Day, Year) State SEP 2 9 2006 Registrar

			1 - For State Amend item#:	State of Mary 18, perFH, G860, 10.	/land / Dep 18.06 TT <sub>Ce</sub>	artment of Health and rtificate of Death	d Mental Hygi Re	ene g. No 2006	32625
<i>\$</i>	Physici		Decedent's Name (First, Midd     ROBERT	A. ARCHER	SR.		2. Date of Death Month SEPTEMBE	ER 26 2006	3. Time of Death 2010 M
	/Medic Examin	_	4a. Facility Name (If not institution PRINCE GEORG	n, give street and number) GE S HOSPITAL		4b. City, Town, or Location of D	eath	4c. County of Deat PRINCE G	_
	/ Funeral Director		5. Social Security Number 291–28–3780		yrs. last birthday Yrs.	If Under 1 Year   If Under 24 H   Months Days Hours N	din. (Month, Day,	9. Birt (Co 1937 OHIO	hplace (State or Foreign untry)
	and and		Usual Residence of Decedent 10a. State 10b. County	/ 10	c. City, Town or L	ocation			10d. Inside City Limits
	Manyi B-f sho	tor	MD PRINC	E GEORGE S	CAPI	TOL HEIGHTS			1 <b>X</b> Yes 2 □ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 5411 NORFIEL	D ROAD		10f. Zip Code 20743	10	g. Citizen of What Co U.S.A.	untry?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show says injury or other traumatic event. The Modical Examinat must be muilled at DDGs.	ρ	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Yes Give	r in U.S. 13.	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 XNo Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify <b>WHI</b>	e, etc.
215-0	thin 72 ho en "natul Medical	Completed		nt's Education est grade completed)  Colfege (1-4or 5+)	(Give	edent's Usual Occupation a kind of work done during most of DO NOT use retired)	working 1	6b. Kind of Business/	Industry
7	led wit lygien her the		12th 17. Father's Name (First, Middle,		AU	TO BODY TECH	Name (First_Middle, M	PRIVATE	
land	uld be fi dental H rked ot tic ever	To Be		CHER		JES	Stitzin	ger	
Maryland	nd 2 shouth and N	2	19a. Informant's Name/Relation: JOYCE ELMORE			ing Address (Street and Number of NORFIELD ROAD (			Zip Code) YLAND 20743
nore,	ages 1 ar nt of Hea t: If item 7 or other		20a. Method of Disposition  1 ★Burial 2 □ Cremation 4 □ Donation 5 □ Other (3	3 □Removal from State	,	osition (Name of imatory or other place)  LLE CEMETERY 10/		Oc. Location - City or	
Baltimore,	permit. P Departme Importani eny injury		21. Signature of Finer Spervice			2. Name and Address of Facility	J. B. JEN	KINS FUNER	AL HOME
(A)			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that caused the tonly one cause on each line.	death. Do not er	7474 LANDOVER R	diac or respiratory arre		Approximate Interval Between Onset and Death
1 Sp. 1	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	a. Uutl Dug to (or as a co	onsequence of):	Vidial Infai Vitery Bise	rction		Oliset and Death
	Examiner	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):	Villey Blse	ase		
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):				
68760,	te be e ysician ie burië	dical		d					
	\$ 0° 8	0 1	IF FEMALE:				<u> </u>		
P.O. Box	that the death certificated by the attending properties as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p  1 Live birth 2 [  4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
	uires that signed b	þ	Part II. Other significant condit	ions contributing to death but n	ot resulting in the	underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed					24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of
Vita	Physician: rthis certifica ral director, i	Be	25. Was case referred to medical examiner?			Othor	Death (Check only one		
ō	Phys or this oral dir	To To	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	ent 3 DOA 4 Nursir	ng Home 5 Resider 28d. Describe hor		cify)
ion	Attending or death. ector: After by the fune	atior	Z _ / tooldon	tigation	ea <i>r)</i> Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	Ital or Attendins after deathers after deather all Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	1 not be mined 28e. Place of Injury building, etc. (3	- At home, farm, s Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
	Hosp 4 hou Funei ely fil	Medical C	29a. Certifier 1 Certify: (Check only one) 2 Medica	ing Physician: To the best of m 15 annuar: On the basis of ex and manner stated	amination and or i	th occurred at the time, date and p nvestigation, in my opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2.	Me	29b. Signature and title of certific	mi dess	1	29c. License number D2892		9-27-0	
Al.	(15)	_		n who completed cause of deat		, Print)			
1	Sta	210	31. Date filed (Month, Day, Year	GH M.D. 7319A F	Signature	RKWAY GREENBELT	,MARYLAND 2	20770	
	Regist		SEP 2 8 2	32. Registrar's	# Apos	W			

DHMH 17 Rev 1/2001

ORIGINAL

1 - State of Maryland / Department Certificate  Certificate	t of Health and Mer e <i>of Death</i>	Reg. No.	06 32626
Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death
Physician Maurice Ronald Anderson		ptember 23,	2006   12:27 a <sup>M</sup>
Examine	Town, or Location of Death  oma Park	4c. County Montge	
Funeral Director 229-08-6713   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under Months   1	1 Year tf Under 24 Hrs. 8. Days Hours Min.	Date of Birth (Month, Day, Year) -07-1964	9. Birthplace (State or Foreign Country) Washington, DC
Usual Residence of Decedent		07 1904	
10a. State 10b. County 10c. City, Town or Location 2		`	10d. Inside City Limits 12 Yes 2 □ No
Maryland P.G. Capitol Heigh  10e. Street and Number  4706 Deanwood Drive  11. Maritat Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 19 Yes 2 No		10g. Citizen of W	Vhat Country?
4706 Deanwood Drive	20743	U.S.	Α.
11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18.	lent of Hispanic Origin? (Specify		e - American Indian, k, White, etc.
Town or Location    10a			Black
15. Decedent's Education (Give kind of work) (Specify only highest grade completed)	l Occupation	16b. Kind of Bu	siness/Industry
Truck Dri	k done during most of working e retired)	Eveready	Rolloff
Truck Dri		rst, Middle, Maiden Surnam	e)
The state of the s	Mary Moo:		-,
T N T T T T T T T T T T T T T T T T T T	(Street and Number or Rural Ro	oute Number, City or Town,	State, Zip Code)
Wade R. Waller/Son Capitol He	ights, Maryland	i	
20a. Method of Disposition    Complete   Com	ther place)		City or Town, State
E 2 5 1	ematory 09-29-	2006 Beltsvi Bacon Funera	ille, Maryland I Home, Inc.
Basis & Wanda (Bacon (134) 3447 14	th Street, N.W.	. Washington,	D.C. 20010
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between
Physician Immediate Cause (Final disease or condition resulting in death)	itis		Onset and Death
/Medical Due to (or as a consequence of):	war Disease		5 years
if any, leading to immediate Due to (or as a consequence of):	JIET Visease		2 45041
Causé. Enter Underlying Causé. Disease or injury that initiated events resulting in death) Last  Co.  Due to (or as a consequence of):			
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic predictions of the past 12 months?	202004	23d. Date	e of delivery
O O O I I I I Yes 2 UNO		Mor	nth Day Year
	ause given in Part I.	23e. Did tobacco use contr	bute to the cause of death?
Chronic Renal Failure  The Total Total Charter Mellitus		1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ★Unknown
Type I Dichetes Mellitus  Type I Dichetes Mellitus		24a. Was an 24b. V autopsy p	Vere autopsy findings available prior to completion of cause of
The second of th		performed? d	leath? □ Yes 22 No
25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (C)		
25. Was case referred to medical examiner?  1	A   A   Nursing Home	5 ☐ Residence 6 ☐ Other Describe how injury occurre	
C S S S S S S S S S S S S S S S S S S S	Work? 1 ☐ Yes 2 ☐ No		
= E D = Duilding, etc. (Specify)	, office 28f.	Location (Street and Number City or Town, State)	er or Rural Route Number,
The state of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of my knowledge, death occurred a second of the best of th	at the time, date and place, and	due to the cause(s) and ma	nner as stated
		t the time date and place a	and due to the cause(s)
(Check only one)  (Check only one)  (Check only one)  (Check only one)	in my opinion, death occurred a	it the time, date and place, a	and age to the cause(s)
(Check only 2) Medical Examination On the basis of examination and/or investigation, and manner stated.  29b. Signature and title of certifier  29c.	in my opinion, death occurred a	29d. Date signed	I (Month, Day, Year)
(3) Coper Whings (1)	in my opinion, death occurred a License number	29d. Date signed Septemb	1 (Month, Day, Year)
(3) Coper Whings (1)	in my opinion, death occurred a	29d. Date signed Septemb	1 (Month, Day, Year)

			For State Registrar	State of Maryla		artment of I			Reg. No. UU	
	Physici /Medic		Decedent's Name (First, Middle,     RICHA)	<sup>Last)</sup> RD GEORGE ALLEI	N			2. Date of Dea Month SEP 2	Dav Ye	3. Time of Death 5:05 P M
	Examin	ALC: Y	4a. Facility Name (If not institution, NATIONAL NAV	give street and number) AL MEDICAL CEN	ΓER	4b. City, Town, BE	or Location of I	Death	4c. County of E	Death TGOMERY
	Funeral Diréctor		5. Social Security Number 162-30-1061	5. Sex 1 ★ 2 ☐ F 6 8	rs. last birthday Yrs.	Months Days		Min. 8. Date of Birt (Month, Da 1 2 – 1 9 –	y, <i>Year)</i> 1937	Birthplace (State or Foreign Country) PA
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD		City, Town or L	ocation Washing	ton			10d. Inside City Limits 1 □XYes 2 □ No
	with the ? Se or 28s-	Director	10e. Street and Number 1601 Skipjacl	Drive		10f. Zip Code 20	744		10g. Citizen of Wha	t Country?
9036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or fleme 23a or 28a-f show wit, the Modical Examination multified at	by Funeral	11. Marital Status  1 Never Married 21 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? d 1 X es 2 No If Yes, Give Year or Dates:	1 U.S. 13.	Was Decedent of If Yes, specify Cut	ian, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. Black
21215-0036	l within 72 h jiene. r than "natu	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		(Giv.	edent's Usual Occu e kind of work done DO NOT use retire Pastor	during most o	f working	16b. Kind of Busin	
	d ta b	To Be C	17. Father's Name (First, Middle, L Theodore	Holiday				s Name <i>(First, Middl</i> e, abeth	Maiden Sumame) Briggs	
Maryland	and 2 should ealth and Men n 27 is marke har traumatic		19a. Informant's Name/Relationsh Dolores Aller	p (Type, Print) Wife				or Rural Route Number		te, Zip Code) on, MD 2074
Baltimore,	Pages 1 aunent of Hearint: If Item		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other (Sp	Removal from State	cemetery, cri	oosition (Name of ematory or other pla on Nat		Date - 11 - 06	20c. Location - City Arlingto	
Baltir	permit. Page Department Important: If any injury or once.		21. Signature of Fineral Service L		1	22. Name and Addr	ess of Facility	Taylor'	s Funera	al Home n. DC 20001
43	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the conty one cause on each line.				irdiac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
8760,	certificate be executed reding physician and use as the burial-fransit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a cont c. Due to (or as a cont d.	sequanca of):					
.O. Box 6	death certif le attending ad for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐Ectopic pregnand☐ Other (specify)	ey		23d. Date o Month	f delivery Day Year
S, P	es tha igned be de	b	Part II. Other significant conditio	ns contributing to death but not		underlying cause g	ven in Part I.			ite to the cause of death?  Probably 4 Unknown
of Vital Record	The faw ate has b page 2 st	Completed						24a. Was autor pendo 1 🗌 Yes	osy prio ormed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \( \subseteq \) No
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatient	2 🗀 ER/Outpatie	ent 3 DOA	hor	of Death (Check only of the control		(Specify)
	ding h. After fune	tion: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day Yea	28b. Time	of 28c. Inju		28d. Describe	how injury occurred	Specify
Division	al or Attend after death Director: d in by the	ertification:	3 Suicide 6 Could n 4 Homicide determi		At home, farm, s	street, factory, office		28f. Location ( City or To	Street and Number ( wn, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C		Physician: To the best of my xaminer: On the basis of examiner stated.						
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		4-3		se number 54801A		29d. Date signed (A	Month, Day, Year)
+	#10		30. Nam and address or person DOUGLAS G. HA		(Item 23a) (Type USN			L NAVAL ME A MD 20889		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	e e				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		rtment of H			iene (	)06	326	528
,	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  All 900d  4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death	2. Date of Deat Month Sept	25	Year 2004 inty of Death	3. Time o	
_	Funeral Director		University of Mary  5. Social Security Number  5.28-82-0752  178	7. Age (In	n yrs. last birthday) 53 Yrs.	Balty If Under 1 Year Months Days	MOTE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 3,	N/ Year) 1953	9. Birthi Cou Uta	place (State ntry) ah	or Foreign
	e Maryland Ba-f ahow	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Cecil		oc. City, Town or Lo	sit						City Limits s 2 √ No
ımore, Marylan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural", or Items 23a or 28a-f ahow any injury or other treumatic event, the Madical Examinational Eaucilliad at Once.	To Be Completed by Funeral Dire	10e. Street and Number  167 Peppermint Dri  11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Glen Allgood  19a. Informant's Name/Relationship (Typ. Linda L. Allgood /  20a. Method of Disposition  1 Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify)  21. Signal red Funey is Service License	2. Was Decedent Ever Armed Forces?  1X Yes 2 Npj If Yes, Give Year or Dates:  Completed)  College (1-4or 5+)  2.  De, Print)  Wife  emoval from State	16a. Decedifie. L. Acquis  19b. Mailin 167 Per 20b. Place of Disportementary, crem Bath Natio	Yes, specify Cub  Yes 22 No  ent's Usual Occup kind of work done OO NOT use retire  ition &  g Address (Street ppermint sition (Name of natory or other pla  onal Ceme	oation ouring most of work c) Chief Material 18 Mother's Nam Marsella and Number or Rur Drive, Pe	ecify Yes or No-Rican, etc.)  ing of Mngmnt e (First, Middle, M Conder al Route Number, ort Depo Date ber 2006 B	Inited  14. F Spe  16b. Kind of  Veter. Maiden Surr  City or Too  sit, 1 20c. Locatio  ath.	mame) wn, State, Zij mary1a on - City or T	can Indian, etc.  ite  idustry  admini  p Code)  and 2  own, State	strati
) !	be executed and leaves and leaves and leaves and leaves and leaves and leaves are provided as a second	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pue to (or as a co	o death. Do not enter  COCCES  Consequence of):  Onsequence of):	er the mode of dyin	-	or respiratory arre			Approxima Interval Bed Onset and	etween Death
C. Box a	s that the death certification by the attending plants and by the attending plants and for use est	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)	у			Date of deliv Month	ery Day	Year
ords, P.	The law requires that the site has been signed by the bage 2 should be detached.	Completed by Ph	Part II. Other significant conditions con	iteration	ot resulting in the ur	monitorio	ven in Part I.		s 2 No		bably 4 [	]Unknown
		0	25. Was case referred to medical				26. Place of Deat		ned?	b. Were auto prior to co death? 1 Yes	ompletion of	s available cause ol
Division of V	Attending r death. ector: After by the fune	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 No Death  2 Accident  3 Suicide  4 Homicide  Homicide  Homicide  Homicide  Homicide  Homicide	ospital:  1 Manpatient  28a. Date of Injury (Month, Day Ye)  28e. Place of Injury- building, etc. (S	- At home, larm, stre	28c. Injui Wor M 1		me 5 Reside 28d. Describe ho 28l. Location (St. City or Towr	w injury occ	curred		mber,
ב	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical Cer	29a. Certifier   1 Certifying Phys (Cneck only one)	ician: To the best of m ler: On the basis of exa and manner stated.	amination and/or inv	occurred at the tirestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and ate and plac	manner as s ce, and due t	stated. to the cause(	(s)
)	To th To th comp	Me	29b. Signature and title of certifier  Worked  30. Name and artifess of person who con	P. Ball  mpleted cause of death  12 G. Gra	land, (Type, I	29c. Licens	18568	5	ept.	gned (Month,		6
	Sta Registr		31. Date liled (Month, Day, Year)	mpleted cause of death 27 G. Gru 32. Registrar's	Signature A	Spark	with the terminal	-/	0.00	1		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician 3, October 2006 0400 **Emma** Jean Addison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F Yrs. Director 574-74-3414 62 Sept. 29, 1944 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 TYYes 2 □ No Director Md. Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rral", or items 23a or Examiner must be r 3227 Bel Pre Road 20906 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 [**X**No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Health and Menta em 27 Is marked 2 James Preston Maxine Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6415 Symposium Way Clinton, Maryland item 27 Rose Preston/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State Pages 1 permit. Pages Department of I Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Cem. 10/9/06 Brentwood, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 . Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str. k, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Metabolic Acidosis Sequentially list conditions, if any, leading to in mount cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed Fecal Peritonitis burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical Sepsis as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 4 signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Gastrointestinal Bleeding 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Renal Insufficiency page 2 s autopsy performed? 2 No 1∐ Yes 2 □ No Massive Fecal Impaction Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 N Inpatient 2 N ER/Outpatient 3 NOA Certification: To nours after death.

Ineral Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred **Division** or Attending 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital e Funeral I 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56691 October 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ghousia Sultana, M.D. 1 12107 Heritage Park Circle, Silver Spring, Md. State

DHMH 17 Rev 1/2001

Registrar

OCT 1 6 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Sandra K. Brooks 32630 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 12, 2006 Κ. Saundra Brooks Medical Examiner 0654 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's 21353 Bristol Avenue Lexington Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex **Funeral** Months Days Hours Country)Texas Director 454-64-2224 08/28/1942 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 XNo 28a-f show St. Mary's Maryland Lexington Park notified at once. Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 9 21353 Bristol Avenue 20653 USA or items 23a 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 XMarried Yes 2 X No Specify: Black 3 Widowed If Yes, Give Year 1 Yes 2 X No specify. permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiele. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinating or the Traumatic event, the Medical Examinate. þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Booker Be Otto Rosalee Hollin 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ၉ Patricia Johnson/Daughter P.O. Box 303 Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State So. Mem. Gardens 9/22/06 Dunkirk, MD Other Specify Donation 5 22 Name and Address of Facility Sewell 1451 Dares Beach Rd Prince Frederick, MD 21. Signature of Funeral Service Licenses Funeral Home action 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interva Physician 8etween Onset and failure. List only one cause on each line. /Medical Death Complications of gunshot wound of torso Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical g physician a UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year use as 1 2 Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 V Unknown 9 Unknown ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 2 No 25. Was case referred to medical 26. Place of Death (Check only one To the Hospital or Attending Physician; æ examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes ဥ 28a. Date of Injury (Month, Day,Year) Feb 2, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot Natural 1600 hrs 1 Yes 2 V No Pending filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 46853 Rogers Drive, Lexington Park, MD within 24 hours a

To the Funeral I determined (Specify) Single Family 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 21, 2006

State Registra

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

111 Penn Street, Baltimore, MD 21201

			1 = For State Registrar	State of	Marylar	nd / Depa	artmer rtifica	nt of He te of D	ealth a Death	and M		Reg. No		32631
	Physicia	an	Decedent's Name (First, Middle, I	,			_				2. Date of De Month	Day	, 2006 <sup>Year</sup>	3. Time of Death
	/Medic		Doroth					stein			Septembe			8:00 A M
	Examin	er	4a. Facility Name (If not institution, g	rive street and numi	ber)			Town, or		of Death			County of Death	
			2021 Tinker Drive 5. Social Security Number 6	Sex 7	Age (In vrs	last birthday)		Washi r 1 Year	If Under	24 Hrs.	8. Date of Bir			
	Funeral Director		180-22-6502	1 M 2⊠XF	76	Yrs.	Months		Hours	Min.	Nov. 20,	y. Year	4 1	place (State or Foreign intry)
			Usual Residence of Decedent				l						rem	sylvania
	yłanc		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	a-fe	ctor	Maryland Prince	eorge's	F	t. Washi	ngton							1 ∐ Yes <b>2√∑</b> 7√20
	th th	)ire	10e. Street and Number				10f. Zi	p Code	07//			10g. Cit	izen of What Cou	intry?
	within 72 hours after death with the Maryland ene. Then "natural", or iteme 23e or 28e-f ehow the Moulcal Exacilities is ust be ricilitied at	Funeral Director	2021 Tinker Drive						0744				USA	
	teme teme	une	11. Marital Status	12. Was Deced	eş?.	J.S. 13.	Was Dece If Yes, spe	dent of His	spanic Ori n, Mexicar	igin? (Sp∈ 1, Puerto	ecify Yes or No Rican, etc.)	-	<ol> <li>Race - Ameri Black, White</li> </ol>	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	IT Yes, GIVE	_		1 🗆 Yes	2 <b>∐</b> No	Specify:				Specify: W	hite
Ş	hour tural	De De	15. Decedent's	Year or Dat	es:	16a. Dece	dent's He	ial Occupa	tion			165 K	ind of Business/ir	
Ċ	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of w	ork done d use retired)	uring mos	t of worki	ng	100.10	ing of Businessin	idustry
77	with iene.	m <sub>o</sub>	Elementary/Secondary (0-12)	College (1-	4or 5+)			e Agen				Sa	ales	
ğ	filed v Hygie other i	BeC	17. Father's Name (First, Middle, La	•					18. Mothe	er's Name	(First, Middle	Maiden	Sumame)	
<u>a</u>	should be t and Mental I s marked or umatic eve	To B	David Leopo:	ld Friedman	1				Molli	.e	Unknown			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Manhal hygiene. Is marked other then "raturat", or theme 23s or 28s-f show aumatic event, it is Moulca Exaciling Least be ricitified at	14	19a. Informant's Name/Relationship	(Type, Print)									or Town, State, Zi	p Code)
Σ	and 2 saith n 27 i		Herman Bornstein /	Husband					- management		nington,	Mary.	land 207	44
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	□Removal from S	20b.	Place of Dispo cemetery, crei	sition (Na matory or	me of other place	)		Date	20c. Lo	ocation - City or T	own, State
Ĕ	Pag ment ent: I ury o		4 Donation 5 Other (Spe		Ka]	las Crem	atory			9/29,	/06	Edge	ewater, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature Funeral Service Lic	censee				nd Addres		UCI			Funeral H	ome PA
	70 E # 9		feg. 18a	w.h-	de .						n Hill,		and 207	
П			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications hat cally one cause on ea	used the dea ch line.	th. Do not ent	er the mo	de of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
, 4	Pnysician :	( W	Immediate Cause (Final disease or condition	- In	l XI	age.	1	ln	her	w	era			Oriset and Death
	/Medical Examiner		resulting in death)	ue to (o	r s a consec	quence (f):		1						
	LAGITITICI	_	Sequentially list conditions,	b. — Due to /s										
	be isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	ras a conse	quence or):								
	and and il-tran	xan	that initiated events resulting in death) Last	c Due to (o	r as a consec	guence of):	·						1	
8760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	a E												
587	ficate physics the	edical		<b>0</b> .										
×	eath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc									23d. Date of deliv	very
Вох	death a atter	ciai	in the past 12 months?	4□Pregna	th 2∏Feta nt at time of o		⊒Ectopic ¡ ⊒ Other (s	pecify)					Month	Day Year
<u>о</u> .	that the de ed by the a detached f	hys	9 □ Unknown	9□ Unknov	vn									
	res that igned b	by Physician/Me	Part II. Other significant conditions	s contributing to dea	th but not re	sulting in the u	nderlying	cause give	n in Part I		23e. Did t	obacco	use contribute to	the cause of death?
ğ	w require been sig should b	edt									10	Yes 2	©Mo 3□Pro	bably 4 Unknown
Records,	law requ as been 2 shouli	piet									24a. Was		24b. Were aut	opsy findings available ompletion of cause of
	The lay ate hes page 2	Completed			-						perfo	rmed? 2003.No	death?	
<u>ra</u>		Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only			
<u>&gt;</u>	hysic nis ce I dire	101	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2□	ER/Outpatier	nt 3 🗆 🗅	OA Othe	r: 4 □ Nu	ursing Ho	me 5⊠ Resi	dence	6 □Other (Spec	ify)
Division of Vital	ng Pl fter tl inera		27. Manner of Death 1x⊠Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury		28c. Injury Work	at ?		28d. Describe	how inju	ry occurred	
Sio	ttendl death. stor: A / the fu	cati	2 Accident investigat 3 Suicide 6 Could no	t he			М		/es 2 🗌					
Ž	l or Att after d Direct I in by	Certification:	4 Homicide determin	200. Place	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, sti ify)	reet, facto	ry, office			28f. Location ( City or To	Street ar wn, State	nd Number or Rui 9)	al Route Number,
Ļ	To the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Director. After this certification properties to the funeral director.		20a Cartifier to Cartifica	Physician: Ta Mari	and of multi-	owledge de-	h access	d makes s		d ala	and due to 40		\	ata ta d
	Hos 24 ho Fund	Medical	29a. Certifier to Certifying (Check only one)	Physicien: To the tamener: On the base and manner	sis of examin	ation and/or in	vestigatio	at the tim	e, date an pinion, dea	nd place, ath occurr	arid due to the ed at the time,	date and	) and manner as d place, and due	stated. to the cause(s)
	within 24 Within 24 To the Fi	Mec	29b. Signature and title of certifier	D V	71		29	c. License	number			29d. Da	te signed (Month	, Day, Year)
	+ 3 F ŏ		1 / / / / / /	117	ANU	nn		200	2 19	954	4	(	9-29-	-06
Λ	(5)		30. Name and address of person with	completed cause	of death (Ital	1/23a) (Type	Print)	, 00	~ 1	0	1		$\int \alpha \int$	00
K	5		EDGIARD 1. 6	MOSLEY		/		od W	av Bo	owie	MD. 207	721		
100	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Sign	ature	- 90	- 0 4	الد رد	وتعديب		<u>4</u> 1_		
	Registr		SEP 2 9 20		w B	L. Comment								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Cequawn Brown Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 25, 2006 1955 hrs Medical Examine R. Brown Cequawn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's Prince George's Hospital Center If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Director Sept. 27, 1989 Country) Wash, DC. 579-17-1911 16 1 X M Usual Residence of Decedent 10d Inside City Limits Oc. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No or 28a-f show Maryland Prince Georges District Heights notified at once be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number United States 1212 Boones Rd. Apt. 3 20747 or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married Yes 2 X No Black Specify Divorce f Yes, Give Year Yes 2 X No specify: "natural" ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than ' injury or other traumatic event, the <u>Medical</u> 21215-0036 School Student 11th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Cecil Crawford Nika Brown 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 1212 Boones Rd. Apt. 3; District Heights, Md. 20743 Nika Brown/Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Harmony Memorial Park Dct. 3, 2006 Landover, MD. Donation 5 Other Specify Pope Funeral Homes 5538 Marlboro Pike Forestville, Md 22. Name and Address of Facility 21. Signature of Funeral Service License 20747 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and 23a, Part I. Ente **Physician** failure. List only one cause on each line /Medical Death a. Gunshot Wounds (2) of Head and Torso Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and trans Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial certificate be Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Month Day 2 Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available this certificate has been prior to completion of cause of autopsy death? performed' ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death 25. Was case referred to medica Division of Vital Be Other<sub>4</sub> examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ပ 1 V Yes 28a Date of Injury (Month, Day Year) Sep 25, 2006 28d Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot 1917 hrs Natural Yes 2 V No 5 Pending within 24 hours after death To the Funeral Director: in by the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town State) determined (Specify) Street 52nd St & Aspen St SE, Washington, DC 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E September 26, 2006 enica 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 0 6 Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician SEPTEMBER 24 2006 3:45 A M INGER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON NURSING HOME CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕏 F Days Hours 49 Yrs. Director 579-72-2084 MAY 14 1957 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at 1 Yes 2 No PRINCE GEORGE'S CAPITAL HEIGHTS Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20743 1002 CYPRESS TREE PLACE death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 XNever Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CO0K 10th or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EVELYN BLACK LARRY WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10512 NORRIS PLACE UPPER MARLBORO, MARYLAND 20774 EVELYN SMITH/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or once. RESURRECTION CEMETERY 9/30/2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, o shock, or heart failure. Light complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIORESPIRATORY FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADVANCED AIDS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 基 Unknown Completed certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No 1 Yes 2₩ No the Hospitel or Attending Physician: . After this certification, funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending after death. Director: Aft 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 24 hours after of Funeral Direct 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of of rifie 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 IRVING STREET N.W. SUITE 415 WASHINGTON, DC ARUNA PASPULA M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 2 8 2006 Registra

DHMH 17 Rev 1/2001

			State of Marylan  State of Marylan	•	artment of H			iene g. No. 00	6 32634
P	£. 8: 8	Ç. 5	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic	_	RACHEL BE	ST			SEPTEM		006 8:00 P M
	Examin	-	4a. Facility Name (If not institution, give street and number) CLINTON NURSING HOME		CLI	NTON			GEORGE'S
	Funeral Director		5. Social Security Number 217-84-8275 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. 44	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, FEB. 23	<sup>Year)</sup> 1962	Birthplace (State or Foreign Country)     ATLANTA, GEORGIA
	aryiand show	70	TOTAL CHORGE C	y, Town or Loc	cation MARLBORO				10d. Inside City Limits 1 XYes 2 No
	with the M s or 28s-f be natifie	Director	MD PRINCE GEORGE S  10e. Street and Number  9125 GRANDHAVEN AVENUE	OTTER	10f. Zip Code 20772			0g. Citizen of Wh	at Country?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If them 21 is marked other than "natural", or flems 23e or 28e-f show or other traumatic event, the Maxical Examiner must be natified at	Funeral	11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 Never Married 2 XMarried 1 Yes 2 No	li li	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc.
200	2 hours at atural', or	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	16a. Deced	1 ☐ Yes 2 ☒ No	Specify:		Specify: 16b. Kind of Busi	BLACK iness/Industry
	e filed within 73 al Hygiene. I other than "na vent, ine Madi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  College (1-4or 5+)	life. L	kind of work done of DO NOT use retired TECHNICIA	)	king	GOVERNI	MENT
	2 should be filed and Mental Hyg Is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last)  FRED STEPNEY			18. Mother's Nam	ne (First, Middle, F E SMITH	Maiden Sumame,	}
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street				
re, ⊾	es 1 and 2 of Health fitem 27 I		ANTHONY R. BEST/HUSBAND  20a. Method of Disposition 1 Burial 2 MiCremation 3 Removal from State	Place of Dispo	GRANDHAV sition (Name of matory or other place				, MARYLAND 20772 City or Town, State
ащшо	Pages ment of lant: If it		4 □Donation 5 □Other (Specify) RIV		E CREMATO				E, MARYLAND
Da	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licensee	7	Name and Address 7474 LAND	OVER ROAL	LANDOVI	ER,MARYL	
	Physician		23a. Part1. Enter the disease, or domplications that caused the deal shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition CARDIORESP)			g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consec	quence of):			-		
,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		12				
Ď,	cate be executed chysician and the burial-transit	I Examin	Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consec	quence of):					
04/80	physic the bi	dlcal	d						
J. Box 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 2 □ No 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	-		23d. Date Mont	of delivery th Day Year
S, P.	es that the de igned by the a be detached t	ρ	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Vital Records	law require as been si 2 should b	Completed					24a. Was a	an 24b. W	fere autopsy findings available for to completion of cause of
ř =	The lav	Con					perfor 1 ☐ Yes		eath? □Yes 2⊠ No
Ž	sician: ] certificel rector, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2	TER/Outration	oth 30 DOA Oth		ith (Check only or lome 5 ☐ Resid		r (Specify)
on of	Attending Physician: or death. ector: After this certific by the funeral director,		1 ☐ Yes 2 ② No 1 ☐ Inpatient 2 ☐  27. Manner of Death 1 ② Natural 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of Injury	f 28c. Injur Wor			ow injury occurre	
Division of	i Dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Speci	iome, farm, str ify)	reet, factory, office		28f. Location (S City or Tow	itreet and Numbern, State)	r or Rural Route Number,
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn (Check only one)  1 Medical Examiner: On the basis of examiner and manner stated.	owledge, deat ation and/or in	th occurred at the tire investigation, in my o	me, date and place pinion, death occu	e, and due to the corred at the time, co	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and attle of certifier		29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)
1	(10)		30. Name and addless of person who completed cause of death (Ite	m 23a) (Tunn	Print)	077		1/2	6100
			ARUNA PASPULA M.D. 106 IRVING	STN	W. SUITE	415 WASH	INGTON.	DC 20010	)
	St Regist	ate rar	31. Date filed (Month, Day, Year) \$2. Registrar's Sign SEP 2 8 2006	ature		· WEIGHT			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of rtificate o	Health a f Death	and M	ental Hy	giene,		32635
	hysic	ian	Decedent's Name (First, Middle, L.	-						2. Date of De	ath		3. Time of Death
	/Medi		Ireatha Rebecc		_				:	Septemi	ber 2	29, 200	6 4:40 a M
<u> </u>	Examir	ner	4a. Facility Name (If not institution, gi 1818 Porter Aven		nber)		4b. City, Town,		of Death			County of Dea	
E	ineral	7			7. Age (In yrs.	Inst histodays	Suit1		24 11-2			ince G	
	rector		577-28-0224	1□M 2€F	86	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da Jan.	V Vaarl	920 Vi	thplace (State or Foreign cuntry) rginia
land	À ==		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						
Man		ţō	Maryland Prince	George		itland							10d. Inside City Limits 1 X Yes 2 No
the the	1 28 1 28 1 28	Director	10e. Street and Number	000280	ba	TCTANG	10f. Zip Code				10g Citiz	en of What Co	
th.	23a		1818 Porter Aven	ue			20746					ed Sta	
r dea	Ē	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Orig	jin? (Spec	ofy Yes or No		4. Race - Ame	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Nett 27 is marked other tran "natural", or feme 23e or 28e-f ehow other treumatic event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1  Yes If Yes, Give Year or Da	2 ( <b>2)</b> No 9		☐ Yes 2 🛣 No		, Риепо н	iican, etc.)	1	Black, White	
2 P	ical E	Completed by	15. Decedent's F	ducation		16a, Deced	ent's Usual Occu	Ination				рта	ack
215 thin 7	Med	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	Aor 5+)	(Give	kind of work done OO NOT use retir	e durina most	of working	g	160. Kin	d of Business	Industry
d 21 filed wi	2 d	Con	12			Admin	strative	Assis	tant		Pr	ivate	
Maryland d 2 should be file th and Mentel Hy	0.0	Be	17. Father's Name (First, Middle, Last Harry Hall.							First, Middle,	Maiden S	Sumame)	
arylan should be ind Mentel	Traffic	ဥ	Harry Hall,  19a. Informant's Name/Relationship (					Se1		Goode			
and 2 she	trec.		John Bell /	Son			g Address (Stree						
re, M	othe	ľ	20a. Metpod of Disposition		20b. P	lace of Dispos	Danwood		Bowi			d 20721	
altimore,	7 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from S	tate	emetery, crem Linco	atory or other pla			,2006		ation - City or	
Baltimore, permit. Pages 1 and Depertment of Heel	eny inju		21. Signature of Funeral Service Light	/							brei	ntwood,	Ma.
<b>n</b> 889	88		Furta/	WHO	1000	5	Name and Address ope Fune	lhomo D	1.1.	Fores	twill	le Mar	yland 20747
			23a. Part 1. Enter the disease of comshock, or heart failure. List only	ofications that ca	used the death	Do not ente	r the mode of dy	ing, such as ca	ardiac or i	respiratory ar	rest,	Le, Mai	Approximate
Physi			disease or condition	·	(215)	ting.	Hear	X F	iste	001			Interval Between Onset and Death
/Med Exam	dical		resulting in death)	Due to (o	r as a gonsequ	uence of):	14.0-0		~~~	VV			-
		-	Sequentially list conditions,	b									
petr	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	ience of):							
exect	ial-tra	Exa	that initiated events resulting in death) Last	Due to (or	r as a consequ	ience of):							
D&/DU, ficate be executed obvision and	as the burial-transit	edicai	(	d									
OX OX Certifica	a as th		IF FEMALE:										
death cer	for use as	any	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	h 2 Fetaf	death 3 E	ctopic pregnanc	v			230	d. Date of deli-	very
	chedi	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of de		Other (specify) _					Month	Day Year
thet a	deta		Part II. Other significant conditions co	ontributing to dea	th but not resul	Iting in the und	lertving cause giv	ven in Part I		23e Did to	hacco uso	contribute to	the cause of death?
w requires been signe	should be detached						, g • g.·	or are detailed		1 🗆 Ye			
law re	2 sho	biet								24a. Was a	n   s		
The The	funeral director, page 2	Completed							_	autops	ned?	death?	opsy findings available ompletion of cause of
clen:	ector,	e :	25. Was case referred to medical examiner?					26. Place of	Death (C	1 ☐ Yes 2	e)	1 🗆 Yes	2 No
Physic this o	la dir	0	1 A Yes 2 □ No	Hospital: 1 ☐ Inp		R/Outpatient	3□ DOA Oth	er: 4 🗆 Nursir				Other (Speci	fy)
Atte	funer	LOI ,	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d	l. Describe ho			
Atten deat	by the	ICa	2 Accident investigation 3 Suicide 6 Could not be	28a Place of	loius. At her	no form start	M 1 ☐	Yes 2 □ No					
a a a a	d in D	Certification	4 Homicide determined	building	, etc. (Specify)	ne, iaim, stree	t, factory, office		281.	City or Town	reet and N , State)	lumber or Run	al Route Number,
ospit hours unere	ly tille		29a. Certifier (Check only 2 Medical Exam	sician: To the be	est of my know	ledge, death o	ccurred at the tim	ne, date and o	place, and	due to the ca	use(e) an	d manner an e	tated
To the Hospital or Attanding Physician: The law requires that the within 24 hours after death.	completely tilled in	Medical	one)	and manner	s of examination stated.	on and/or inves	stigation, in my o	pinion, death o	occurred a	at the time, da	ate and pla	ace, and due to	o the cause(s)
200	9	=   2	29b. Signature and title of certifier	Han		-	29c. License	number	.7	> 25	d. Date s	igned (Month,	Day, Year)
(P)		_		CUN.	0		TV	116	1 -		10	121	06
G	0	3	O Name and address of person who o	ompleted cause of	death (Item 2	23a) (Type Pri	nt)	1 Do	1#	2014	(1	>10dm	M1120+
	State		11. Date filed (Month, Day, Year)	32. Regi	strar's Signatu	re	IN VEN	10/ 6-6	7 /	10111	1	I ELE DY	1/111.35
Re	gistra		OCT 0 3 2006	eur de	do	K)							

			1 - For State Registrar	State of Marylan		artment of rtificate of		nd Menta		ne 2.006	32636
	Diam'r.		1. Decedent's Name (First, Middle, I	Last)					ite of Death	Day Year	3. Time of Death
	Physici /Medic		ARTHUR	FRANKLIN	ВС	RTLE		SEP	r. 2	8, 2006	4:00 P M
	Examin		4a. Facility Name (If not institution, g				or Location of [	Death		4c. County of Deat	
			12360 POINT VIEW			BISHOP		Hre a D-	to of Birth	WORCESTE	
	Funeral Director		215-42-6478	. Sex 7. Age (In yrs. 17 M 2□ F 64	Yrs.	Months Days		Min. (M	te of Birth onth, Day, Ye $\Gamma$ . $10$ ,	9ar) 9. Bin Co 1942 MAR	hplace (State or Foreign untry) YLAND
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Aanyl f sho	ъ,	MARYLAND WORCE	стгр В	SISHOPV	TTTE					1 ☐ Yes 2√ No
	the t	Director	MARYLAND WORCE  10e. Street and Number	BIEK L	OLDIIOI V	10f. Zip Code		-	10g.	Citizen of What Co	untry?
	ath with the Marylan 23a or 28a-f show ust be notified at		12360 POINT VIEW	RD.		218	13			USA	
	ms 2:	by Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin	n? (Specify Y	es or No-	14. Race - Ame	
က	or Ite	Ē	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give				Pueno nican,	etc.)	Black, Whit	
<u>8</u>	hours a		3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ∏ N	о зрвену.			Specify: WH	LTE
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Exact rest be notified at	Completed	15. Decedent's (Specify only highest)	Education grade completed)	(Give	dent's Usual Occi	e during most o	of working	161	b. Kind of Business/	Industry
2	within lene. than "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir ${ m IR} \ \ \& \ { m FAB}$			м	ANUFACTUR	TNC
	filed within Hygiene. other than		10 17. Father's Name (First, Middle, La	net)	WELDE	AR & FAD		Name (First		iden Sumame)	LING
anc	ould be fi Mental H warkad ot matic ever	Be	ERNEST S.	BORTLE, SR			MARY		TELLA	GOSSNE	T.
Maryland	should I ind Meni i marka umatic	은	19a. Informant's Name/Relationship		19b. Mailir	na Address (Stree				ity or Town, State, 2	
Z	C1 (0 = 16				İ	•				-	AND 21813
ē,	other tr		PATRICIA ANN BORT  20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of		Date		c. Location - City or	
JO L	ages ant of it: If i	1 8	1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State		natory or other p		/29/06	D	ELMAR, DE	LAWARE
altimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Juny ral Service Lie			2. Name and Add					
Ba	permi Depa Impo any ir		11/1/1/2 11	14	TIA	CTINCC	ETIMED AT	HOME	CEIRV	VILLE, DE	19975
			23a. Partf. Enter the disease, or co shock or heart failure. List or	emplications that caused the deat	Do not ent	er the mode of d	ying, such as ca	ardiac or resp	iratory arrest	, VIIIIII 6 171	Approximate Interval Between
	Physician		Immediate Cause (Final			at De	ectum				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		3/					3 years
	Examiner			b							
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (U.S. ause of injury)	Due to (or as a conseq	uence of):						
	cuted nd ransi	Examine	that initiated events	c							
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate thys	Physiclan/Medical		d							
9	eath certific attending pi for use as t	Med	IF FEMALE:								
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	I death 3	Ectopic pregnan	псу			23d. Date of de Month	ivery Day Year
<u>.</u>	it the de by the a tached f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leath 5	Other (specify)					
P.O.	that the	F	Part II. Other significant condition	s contributing to death but not res	ulting in the u	nderiving cause of	niven in Part I.	2:	3e. Did tobac	cco use contribute to	the cause of death?
of Vital Records,	signed signed d be de	d by	•	•	•	,	,		1 🗆 Yes	2.00 3 □ Pr	obably 4 Unknown
Ö	w require been significations	ete							4a. Wasan	24h Were at	itopsy findings available
Rec	has has	Completed						-   -	autopsy performe	d2 prior to death?	completion of cause of
a			25. Was case referred to medical				00 Plans			No 1 □ Yes	2 □ No
₹		o Be	examiner?	Hospital:	IED/Outpation	nt 3 DOA		f Death (Che		e 6 □Other (Spe	cifu)
of	ig Phys ter this neral di	7:	27. Manner of Death	28a. Date of Injury	28b. Time o	The second secon				injury occurred	uny)
on	ding It. th. : After s funer	ig ig	1 Natural 5 Pending 2 Accident investiga	(Month, Day Year) tion	Injury		fork? ∐Yes 2∭No	0			
Division	or Attendialter death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of Injury - At h building, etc. (Specif	ome, farm, sti	reet, factory, offic	е	28f. Lc	ocation (Streetity or Town, S	et and Number or Ri	ural Route Number,
Ö	safter safter saft Direct	Cert	4 I Homode	building, etc. (Specif	<b>y</b> /				., ., ., .		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of my kno caminer: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and du occurred at t	ie to the caus he time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	1		29c. Lice	nse number		29d.	. Date signed (Mont	h, Day, Year)
	- 1/D		141 M	, Com		0	30690	>	5e	pt. 29.	2006
	1200		30. Na if and address of erson wi	no completed cause of death (Iter	n 23a) (Type.	Print)				,	
	10.		Jones E. MA	DATIN, M.D.	145	E. Cari	roll 57	t., 5	Tel. 5	bury. N	10 21801
	Sta	ate	31. Date filed (Month, Day, Year)	9 2006 32. Registrar's Signa	ature	<i>A</i> .		,		7	
	Regist	rar	SEP 2	9 ZUUB BROWNER	11 1	marke					

			riease i	Otet of Manda			•	•	
			1 _ For State	State of Marylan	•		мептаі нус	giene2 0 0 6	32637
			Registrar Registrar		Certifica	te of Death	-T	Reg. No.	
	Physicia	an	Decedent's Name (First, Middle, Last)	ກ ຄ.	i .		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Inelma	B. Dicc	h	T	09	26 06	2200 M
7	Examin	er	4a. Facility Name (If not institution, give :	11	40. City	, Town, or Location of Deat	n	4c. County of Dea	m . M 1 CD
			5. Social Security Number 6. Sec	Med 1001 Last	last hirthday) If Und	er 1 Year If Under 24 Hrs	8 Date of Birt		thplace (State or Foreign
	Funeral Director			M 200F	Yrs. Months			y, Year) Co	ountry) VA
			Usual Residence of Decedent	[0]			1 23	1103	
	show		10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
	a-f s	cto	VH Accom	rack W	alloos	Island			1 Yes 2 No
	deeth with the Maryland ms 23a or 28a-f show rirust be notified at	Director	10e. Street and Number	. 1	10f. Z	ip Code		10g. Citizen of What Co	ountry?
	23a	rai	8103 Mifflin	Rd.		23337		U.S.	A
	ar de	Funeral		<ol> <li>Was Decedent Ever in U. Armed Forces?</li> </ol>	.S. 13. Was Dec	edent of Hispanic Origin? (5 ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
900	hours after tural', or ite al Examina	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 ☐ Specify:		Specify: \	hite
3	in 72 hours after deeth with the Maryla "natural", or Items 23s or 28s-1 show Goal Examiner must be notified at	ed	15. Decedent's Edu		16a. Decedent's Us	ual Occupation		16b. Kind of Business	
<u>.</u>	within 72 ene. than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give kind of w	ork done during most of wo use retired)	rking	_	^
77	d with giene	mo:	la	College (17401 5+)	Home	mater		Sel-	
<u> </u>	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)	1		18. Mother's Na	me (First, Middle,	Maiden Surname)	
/Ian		To E	John F. B	seauchamp	>	Mary	Wil Wil	liams	
Mar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Addre	ss (Street and Number or A	ural Route Numbe	er, City or Town, State,	Zip Code)
ອ ອົ	s 1 and if Heelth item 27 other tr		Marie Purdy	1 Daughter	8103 m	fflin Ad	Wallops	Island, V	A 23337
E .	00		20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □ F		Place of Disposition (N. cemetery, crematory or	other place)	Date	20c. Location - City or	Town, State
	. 5 5 3		4 ☐ Donation 5 ☐ Other (Specify)	120	hn W. Taylo	The Carried I	30/2006	Temperan	ceville UA
galt	Depart Depart Import any in		21. Signature of Funeral Service Licens	<del>30</del>	0 1	and Address of Facility		1 /	14 2333L
	40000		23a Part 1 Enter the disease or comple	ications that caused the death	b Do not enter the mo				Approximate
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	1		o or respiratory ar	1031,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	caran		disease			inknow
	Examiner			Due to (or as a conseq	uence or):				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
o Î	be executed iclen and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):				
3/60	e X e	ical		1					
20	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE:						
X D	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3 □Ectopic			23d. Date of de Month	livery Day Year
	be d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 Other (	specify)			,
7	uires that the d signed by the Id be detached	Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
cords,	8 6 6	d by	dehydatus				1 🗆 Y	res 2.21No 3□P	robably 4 Unknown
Ö	≥ 0 20	iete	read in El	^ ,			24a, Was	an 24h Were a	utonsy findings available
a)	The lay	ompieted	Tage Insult	arnay			autop perfo	rmed? death?	utopsy findings available completion of cause of
	ician: The lav certificete hes rector, page 2	O	25. Was case referred to medical			26. Place of De	1 ☐ Yes ath (Check only o		s 2□ No
<u> </u>		To B	examiner?	lospital:	ER/Outpatient 3 [	Others		dence 6 □Other (Spe	ocify)
יס ר	ng Ph ter th		27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		now injury occurred	,,
<u> </u>	Attending Physician: r deeth. sctor: After this certific by the funeral director.	atic	2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No			
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory)	ry, office	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
2	pitel i		200 Conting				1		
	To the Hospitel or Attending Phys within 24 hours attend death. To the Funses Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one)  Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occurre ition and/or investigation	d at the time, date and place n, in my opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	and marrier stated.	_	9c. License number		29d. Date signed (Mont	
1	( N N )		Child			D30853		9/27/06	2
1	Melly		30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type, Print)				
1	/		Charles A. S. Ivi	***	Permenta	D30853 Regimal Medic	ial Center	. Salisbury	mo
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture				
	Registr	ar	SEP 2 9 21	JUD Page	20 11 11				

DHMH 17 Rev 1/2001

2562-80-622

Birch

ORIGINAL

			1 - For State Registrar	State of Maryland	Cert	ificate of L	Death		leg. No.	000	32638
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Ruby	Marie		ddle		Septem			1224
	Examin	er	4a. Facility Name (If not institution, give s		1	4b. City, Town, or	Location of Death	•	4c. C	ounty of Deatl	h '/
			Peninsula Regional			Salisbu		100. (5:0	Wi	comico	
	Funeral		5. Social Security Number 6. Sex	M 200 F	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year)		hplace (State or Foreign untry)
L.	Director		213-22-7540	79	113.			07-11-1	927	Stoc	kton, MD
	land ow		10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Man,	ţ	DE Sussex	De	elmar						1 ☐ Yes 2X No
	with the Maryland o or 28e-f show be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Co	untry?
	h wit		13409 Oak Branch R	.oad		19940			US	2 Δ	
	deet	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	3. W		spanic Origin? (S	pecify Yes or No- o Rican, etc.)		. Race - Ame	
2	after or its		1 Never Married 2 Married	Armed Forces? 1  Yes 2 No If Yes, Give		Yes 2X No		o rican, etc.)		Black, White	
3	72 hours after deeth with the Maryland Inatural; or Itema 23e or 28e-f ehow disal Examinat must be notified at	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:			ороспу.		3	specify: Wh	ite
0000-0	swithin 72 hours after deeth w jiene. r than "natural", or items 23a the Madicel Examinat must it	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decede (Give k	ent's Usual Occupa ind of work done of O NOT use retired	ation Juring most of wor	rking	16b. Kind	d of Business/	Industry
7	within ene. then	g E	Elementary/Secondary (0-12)	College (1-4or 5+)			)		ъ.		
7	filed y Hygie other I		17. Father's Name (First, Middle, Last)		Sale	es Clerk	18 Mother's Nan	ne (First, Middle,		il Sto	re
ylaild	od be	Be	Roy L. Jones							umanio)	
	should nd Men marke umaric	ဥ	19a. Informant's Name/Relationship (Ty)	ne Print)	19h Mailing	Address (Street		ine Domar Iral Route Numbe		Town State 7	7in Code)
Z	12 a 7		Ruby G. Riley - da								
Ď	Tea Hea		20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of		Date L'ai	20c. Loca	ation - City or	MO 21849 Town, State
palminore,	permit. Pages: Depertment of H Important: If Ite any njury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovai irom State	-	atory or other plac	1	00.0006	•••		
	ortan		21. Signature of Funeral Service License		.11g11111	Name and Address	a of Facility	02-2006_			
ă	Per de pe		Millie The	es Klock O			DC	ounds Fur			201
			23a. Part1. Enter the disease, or complishock, or heart failure. List only	ations that caused the death.	Do not ente	r the mode of dyin	n Street g, such as cardiac	Salish	oury., rest,	MD 21	Approximate
	Physician		Immediate Cause (Final								Interval Between Onset and Death
}	/Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	1000					MONTHS
	Examiner			Due to (or as a consequence of the consequence of t	E-S	MEL	LITUS				Lowes
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ							10 000
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
5	e exe ien a urial-l	Ä	resulting in death) Last	Due to (or as a consequent	ence of):						
	ificate be executed physicien and as the burial-transit	edicai									
4		Med	IF FEMALE:			10.50	Heritica de la composición dela composición de la composición de la composición dela composición dela composición dela composición dela composición de la composición de la composición de la composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición d		1		
ב ב	death cert e attendin od for use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23	d. Date of deli Month	ivery Day Year
5	the a	Physician/M	1 Yes 2 No	4☐ Pregnant at time of de 9☐ Unknown	ath 5	Other (specify)				MONUI	Day Feat
	ires that the death certif signed by the attending d be detached for use a	F.	Part II. Other significant conditions con	tributing to death but not requi	Iting in the uni		on in Dant I	220 Did to	basso us	0.000155140.40	the cause of death?
Ď.	requires that the een signed by th nould be detache	1 by	Tarris ottor significant conditions con	and the trace of the same of the same	iting in the unit	Jerrying Cause give	enin ranti.		es 2		
200	w requir been si should	Completed									
ב	a 2 0	ם						24a. Was autop	sy	24b. Were au prior to death?	topsy findings available completion of cause of
	iclan: The certificate harector, page			-				perfor 1 ☐ Yes	2 No	1 Yes	2 🗆 No
=	eiclan: certific rector.	Be	25. Was case referred to medical examiner?	ospital:		3C DOA Othe	_	ath (Check only or			
5	Phys r this ral dir	7	1 Yes No	Mulinpatient 2 LE	R/Outpatient 28b. Time of	3 DOA 28c. Injun	4 🗆 Nursing r	fome 5 Resid			cify)
5	ding Phi th. After thi funeral	ţ	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work	(? Yes 2∐No	Zou. Doscribe in	ow alluly	occurred	
DISINI	or Attending Physician: ifier death. Director: After this certific in by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	me farm stre			28f. Location (S	Street and	Number or Ru	ural Route Number,
Ś	2 4 7 6	Certification;	4 Homicide determined	building, etc. (Specify)	)			City or Tow	m, State)		
	Hospital		29a Certifier 1 ertilying Phys	strian: To the best of my know	rladge, death	onnumed at the tin	e, date and place	a, and dual to this e	aucu(c) a	nd manner as	stated.
	ne Hospital on 24 hours all ne Funerel Dietely filled in	Medicai	(Check only 2 Medical Examination)	ner: On the basis of examinati and manner stated.	on and/or inve	astigation, in my of	pinion, death occu	irred at the time, o	date and p	lace, and due	to the cause(s)
	To the with n 2 To the complet	Σ	29b. Signature and title of certifier	0		29c. License	number		29d. Date	signed (Monti	h, Day, Year)
	118		7. Simed	con, M.	Phi	05	3629		9/	28/10	S
	X		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре, Р	rint)	~ W O [	8		- 10	
			110 mares 200 miles	man and the second	The second second			The second secon			
3	0		31. Date filed (Month, Day, Year)	32. Registrar's Signati	OF SH	in that	ED:	41.504	14,1	no J	1807

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [ ] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Physician 0530 September 27, Brown 2006 White Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital of Cecil County E1kton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖸 F 1916 213-20-0165 Kentucky 89 8, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City. Town or Location 10a State 10b County r than "natural", or items 23a or 28a-f show the Medical Exaction must be notified at 1 Yes 2X No Perryville Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 125 Browns Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. within 72 hours atter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ð 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Brownies Restaurant filed within Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) Perryville, Maryland Self-Employed Owner/Operator Eight Years other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jiny or other traumatic event 2002: Laura Hill Patsey Pasquali Bianchi White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Browns Road, Perryville, Maryland 21903 Roberta Jean Hawley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 

■ Burial 2 □ Cremation 3 □ Removal from State 09/30/06 Angel Hill Cemetery Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer see 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. M. Laterson, Gr. 21903-0766 Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Sop 5 is Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Sigmoid colon Personated Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and 1 for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached to Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thrombophlebitis 1 Yes 2 No 3 Probably 4 Unknown peeu Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospitel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of Atifier Sachders AD D0023322 9.27.06. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEV MD //8/Virial S/ S/ 118 North SI Suite 3B Eletin MD 21921. SACHDEN 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State OCT 0 2 2006

Registrar

			1 - State Registrar	tate of Marylan		artment of I			giene 100 6	32640
	Physici		Decedent's Name (First, Middle, Last)     Robert Newton Bow.	ers			<del></del>	2. Date of Dea Month Septemb	Day Year	3. Time of Death 5:00 P M
	/Medio		4a. Facility Name (If not institution, give streethomewood Retirement			-	i amsport		4c. County of Dea Washingt	th
1.	Funeral Director		5. Social Security Number 220-10-3124  Usual Residence of Decedent  6. Sex 1X M	7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 16		thplace (State or Foreign buntry) y l and
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Iteme 23e or 28e-f show int, the Mudical Examinar intuit the Livillied at	ector	10a. State 10b. County  Maryland Washington  10e. Street and Number		/, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1 Tyes 2 X No
	th with	al Dir	16505 Virginia Ave.	Apt.319 8	3		795		USA	outuy:
920	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "naturel", or iteme 23a or 28a-f show event, the Mudical Examinet must be invitted at	by Funeral Director		Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No 194 If Yes, Give Year or Dates: 1946	. 5ー	Nas Decedent of I f Yes, specify Cub	Hispanic Origin? (S) an, Mexican, Puent Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	filed within 72 ho Hygiene. Sthor than "natur ent, 1.e Mydical	Completed	15. Decedent's Educati (Specify only highest grade co	on empleted) College (1-4or 5+)	(Give lite. l	lent's Usual Occup kind of work done DO NOT use retire	during most of word)	king	16b. Kind of Business Heating Su	·
Maryland 2	d la b	To Be C	17. Father's Name (First, Middle, Last)  Eugene Baker Bowers					ne (First, Middle, Naom i Ho	Maiden Sumame) ffman	· · · · ·
ds.	and lealth m 27 her ti		19a. Informant's Name/Relationship ( <i>Type</i> , Bernice W. Bowers — 20a. Method of Disposition	Wife 20b. P	16505	•	a Ave. Ap		r, City or Town, State, A Williamspo 20c. Location - City or	ort,MD 21795
Baltimore,	permit. Pages 1 Department of H Important: If Ite ony injury or ot		1 Name   2 Cremation   3 Remote   4 Donation   5 Other (Specify)   21. Signature of Funeral Structure   10 Stru	Oval Holli State	t Have	en Cemete . Name and Addre	ry Oct.3	sborne F	Hagerstown, uneral Home illiamsport	e,P.A.
10	Physician /Medical Examiner	)-L	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of the sease or condition resulting in death)  Sequentially list conditions, if any leading to immediate.	ons that caused the death ause on each line.  Penal F  Due to (or as a consequence of the	ailure	er the mode of dyn		or respiratory ari	est,	Approximate Interval Between Onset and Death
,09289	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:	Due to (or as a consequ	rence of):					
P.O. Box	at the death certifica by the attending pl tached for use as t	Physician/Med	23c. 23c. in the past 12 months?	If yes, outcome of pregna. 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 [	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	w requires that been signed I should be det	by	Part II. Other significant conditions contrib	uting to death but not resu	ilting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to es 22No 3□Pi	the cause of death?
Vital Records,		Completed	gont	ulan disc	200.			24a. Was a autops perfor 1 🗆 Yes	sy prior to	utopsy findings available completion of cause of
Vit	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes  No Hosp	oital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Ott		th Check only or	ence 6 □Other (Spe	av6.c)
	ding After fune			8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			ow injury occurred	city)
Division	ital or Attencirs after deathral Director:	Certification:	4   Homicide	8e. Płace of Injury - At ho building, etc. (Specify	·) 			City or Tow	,	
	To the Hospital or a within 24 hours after To the Funeral Directorpletely filled in the completely filled in the completely filled in the fill	Medical	one)	an: To the best of my know On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation, in my o	opinion, death occur	and due to the c red at the time, d	ause(s) and manner as late and place, and due	s stated. to the cause(s)
)	To Ton	2	29b. Signature and title of certifier	0		29c. Licens	3 3		29d. Date signed (Mont	
S	H-5+		30. Name and address of person to comp	0 13494	Par	Print)	- Avery	e Hagi	813600 m	006 D 21747
-47	Sta Registr	-	31. Date filed (Month, Day, Year) 0CT 0 2 200	32. Registrar's Signat	M. A	celes		J		

06-07573 Aranka Behymer Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physician  all colored Remains  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aranka Aurelianna Barbara Behymer  Aberdeen  101 Cambridge Avenue  5 Social Sexuiny Number  5 Social Sexuiny Number  5 Social Sexuiny Number  6 Sexuiny Number  6 Sexuiny Fred Goden  100 City, Town or Location of Deadh  Aug. 11, 1941  100 City Town or Location  Aug. 11, 1941  100 City Town or Location  Aug. 11, 1941  100 City Town or Location  Aug. 11, 1941  100 City Town or Location  Aug. 11, 1941  100 City Town or Location  Aurelian Type Julianna  101 City Town or Location  Aurelian Type Julianna  102 City Town or Location  Aurelian Type Julianna  103 City Town or Location  Aurelian Type Julianna  103 City Town or Location  Aurelian Type Julianna  104 Indied City International Type Julianna  105 City Town or Location  Aberdeen  105 City Town or Location  Aberdeen  107 City Town or Location  Aurelian Type Julianna  108 City Town or Location  Aurelian Type Julianna  108 City Town or Location  Aurelian Type Julianna  109 Citizen of Whist Country?  100 City Town or Location  Aberdeen  101 Zip Code  21001  11 Marial Status  12 West Decedents Ever in U.S.  13 West Decedent Ever in U.S.  14 West Status Country?  15 Boedeferts Education (Speedy only highest grade competency)  15 Boedeferts Education (Speedy only highest grade competency)  16 Boedeferts Location (Speedy only highest grade competency)  17 February Remains Country  18 Monther's Name (First Models, Last)  18 World Remains Status Country  19 City Status Country  19 City Status Country  19 City Status Country  19 City Status Country  100 City Town Status Country  100 City Town Status Country  11 West Status Country  11 West Status Country  12 West Decedents Lucus Country  13 West Decedents Lucus Country  14 West Stat	mits
Funeral Director  Funeral Burden Funeral Burden Funeral Director  Funeral Burden Funeral Burden Funeral Director  Funeral Burden Funeral Burden Funeral Burden Funeral Burden Funeral Congreta Funeral Director  Funeral Burden Funeral Burden Funeral Director  Funeral Burden Funeral Burden Funeral Congreta Funeral Director  Funeral Burden Funeral Substitution Funeral Funeral Burden Funeral Burd	mits
Funeral Director    Social Security Number   S	mits
Director    O64-36-3452   1m   2k   F   65   1m   2k   7   7   7   7   7   7   7   7   7	mits
10a. State   10b. County   10d. Inside City Lift   1	
Programmer   The state of the s	No
Programmer   The state of the s	53
Programmer   The state of the s	77
Programmer   The state of the s	33
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	1
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	
1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   1 Burial 2 Cremation 3 Removal from State   Harford Mem. Gdns. 10/13/06 Aberdeen, Maryland   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Signature of Funeral Service Licensee   22 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   21 Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facility   Tarring-Cargo Funeral Home, P.A.   Aberdeen, Maryland   Name and Address of Facilit	
Physician / Medical Examiner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enal Underlying Cause (Disease or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that	
Physician / Medical Examiner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enal Underlying Cause (Disease or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that	
Physician / Medical Examiner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enal Underlying Cause (Disease or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that imitated Course (Disease Or injury that	
failure. List only one cause to each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause Enait Underlying Cause (Disease or injury that initiated (Disease or i	erval
or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate course Enter Underlying Course (Disease or injury that initiated (Disease or injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury tha	
if any, leading to immediate  Lease Erner Underlying Cause (Disease or injury that initiated Consequence of Con	
Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):	
d.    AMENDED   Landing and and and an an and an and an an and an an and an an and an an and an an and an an and an an an an an an an an an an an an an	_
र्व हर्न्न 😃   UNPENDED   AMENDED	
O a control of the co	
Jeggy Jacob	
O = January   I   Yes 2 V No 9 Unknown   9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of t	
L s be be like to like the second of the sec	
24a. Was an autopsy findings avail autopsy performed?  1 Ves 2 No 1 Ves 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	of
24a. Was an autopsy findings avail prior to completion of cause death?  1	,
was case referred to medical examiner?  1 V Yes 2 No  28 Place of Death (Check Only Only)  1 V Yes 2 No  1 Place of Lewis 1 298 Joins of Medical Properties of Medical Properties of Medical 1 Inpatient 2 ER/Outpatient 3 DOA  1 Place of Lewis 1 298 Joins of Medical Properties of Medical	
E E C O I V Natural - D	
25. Was case referred to medical examiner?  1 Ves 2 No Dither Scene  26 Place of Death (Check only one)  27. Manner of Death  1 Ves 2 No Dither Scene  28a. Date of Injury (Morth, Day, Year)  27. Manner of Death  1 Natural  28a. Date of Injury (Morth, Day, Year)  27a. Manner of Death  28b. Time of Injury (Morth, Day, Year)  28b. Time of Injury 28c. Injury at Work?  27b. Was case referred to medical examiner?  28d. Describe how injury occurred	City
28. Place of Injury - At home, farm, street, factory, office building, etc.  Solution (Street and Number or Rural Route Number, or Town, State)  28. Location (Street and Number or Rural Route Number, or Town, State)	
2 Accident 3 Suicide 6 Could not be determined (Specify)  2 Suicide 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Specify)  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Specify)  29b. Signature and title of Certifier (29c. License number) 29d. Date signed (Month, Day, Year)	
mel 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b. Signature and title of Cettifier  29c. License number  29d. Date signed (Month, Day, Year)	
O.C.M.E. October 8, 2006	
30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31 Date filed (Month, Day, Year) 32. Registrar's Signetüre	

06-07194 In Choi

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Ce	rtificate of Death	Reg No. 2006	32642
Physician Medical Examine			Month Day Viv	ime of Death 2019 hrs
	4a. Facility Name (if not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of Death Rockville	4c. County of Death  Montgomery	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24Hrs	. 8 Date of Birth (MM/DD/YYYY) 9. Birthplac	
Director	227 73 9146 1 XM 2 F 5	Months Days Hours Min	JUNE 19 1956 Country	S KORE
v any	10a. State 10b. County 10c. City	r, Town or Location		. Inside City Limits
daryland 28a-f show any 1 at once.		10f. Zip Code	10g Citizen of What Country?	XYes 2 No
ith the Maryland 23a or 28a-f she notified at once	1	20120	SOUTH KOF	REA
hours after death with the Maryland natural", or items 23a or 28a-f sh.  Examiner must be notified at once	11. Marital Status 1 Never Married 2 Married Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? ( Sp. 14 Yes, specify Cuban, Mexican, Puerto		ndian, Black,
s after de rral", or niner mu	yvidowed 4 Divorced in res, give real or Dates:	1 Yes 2 No specify:	Specify: ASIAN	
51 3 = 1 d	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of volume during most of working life, DO NOT use reti		try
5-0036 led within 72 hour Hygiene. other than "natu	12	LABOURER	CONSTRUCT	ION
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	DONG CHOI		(First, Middle, Maiden Surname)  HUH	
MD 21 dd 2 should ulth and Me nn 27 is mar aumatic ev		19b. Mailing Address (Street and Number or I	Rural Route Number, City or Town, State, Zip	
		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town	
Baltimore, Department of He, Important: If ite	4 Donation 5 Other Specify:	10.11	/26/6 ALEXANDRIA	
Balti permit Departin Imports	21. Signat of Funeral scelling has be		ARLES HINDS FUNER  IVE UPPER MARLBOR	
Physician /Medical	failure. List only one causi on each line.	h. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart Ap	proximate Interval etween Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a Occlusive Coronary Ar Due to (or as a consequence or condition resulting in death)	of):		
)	Sequentially list conditions, if any, leading to immediate b. Atherosclerotic Cardio Due to (or as a consequence			
red nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	of):		
xecuted n and - transit				
760, frate be executed physician and the burial - transi	IF FEMALE: 23c. If yes, outcome of pre	gnancy	23d Date of delivery	
68 certiff	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of december 1.	2 Fetal death 3 Ectopic pregnateath 5 Other (Specify)	nncy Month Day	Year
. B. the de by the by the de f	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e Did tobacco use contribute to the c	ause of death?
ires that the signed by the detact			1 Yes 2 No 3 Probably	4 Unknown
Records, The law requires freate has been sig. page 2 should be			24a. Was an 24b. Were autopsy prior to complete death?	findings available letion of cause of
tal Rec		26.Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Yes	2 No
F Vital   Physician: This certifial director,	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 V	ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6 Other:	
on of ording Path		28b. Time of Injury 28c Injury at Work?	28d. Describe how injury occurred	
Division of Vital Records, bopital or Attending Physician: The law requirements after death meral Director: After this certificate has been siy filled in by the funeral director, page 2 should the forthis or To Be Completed.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At 1	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural R or Town, State)	oute Number, City
e Hospital 124 hours e Funeral letely filled		dge, death occurred at the time, date and place, and	due to the cause(s) and manner as started.	
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cau	
(5)	29b Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Description of September 24, 2006)	
	30. Name and address of person who completed cause of death (Ite	,		
Stat	Patricia Aronica-Pollak MD. Assistant Medical  31. Date filed (Month, Day, Year)  2. Registrar's Sigga		e, MD 21201	
Registra	A 0 17 0000	Sports.		

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of M	laryland /		rtment <i>tificate</i>			nd M			00	6	32643
	Physici	1.00	1. Decedent's Name (First, Middle,	Last)		_					2. Date of Dea Month	Day		'ear	3. Time of Death
	/Medic	al	Mary E. Cherr		1		4b City T	OWD OF	Location of	f Death	09	27	2006 County of		11:55 p M
	Examin	er.	Laurel Regional		/		Lau		Location	Death			ince		roe
	Funeral			. Sex 7. A	ge (In yrs. last b	irthday)	If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birti	7			place (State or Foreign
N <del>e</del> ff. Sab-	Director		218-16-2103	1 □ M 2 🗗 F	82	Yrs.	Months	Days	Hours	IVIII I.	01/19/	1924	Ţ		ington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						<del></del>		IOd. Inside City Limits
	Maryli f sho	ō	Maryland Prince	George	Co1	lege	Park								1X Yes 2 □ No
	28a-	rec	10e. Street and Number				10f. Zip (	Code				10g. Cit	izen of Wh	at Cou	ntry?
	th with	by Funeral Director	9408 52nd Avenue				2	0740	)				USA		
	lema sermi	Juer	11. Marital Status	12. Was Deceden Armed Forces	?	13. \	Was Decede f Yes, speci	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			Amen White,	can Indian, etc.
36	rs afte	y Fi	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates			1 ☐ Yes 2	X No	Specify:				Specify:	Whi	lte
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or itema 23a or 28a-f show event, the Medical Exeminer must be notified at	ted	15. Decedent's	Education		a. Deced	lent's Usual	Occupa	ation			16b. K	ind of Busi	ness/In	dustry
215	within 7; ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	5+)	lite. L	kind of work DO NDT use	e retired	uring most )	or worki	ng				
21	e filed within al Hygiene. I other than vent, the Ma	Sol	12		L	ega1	Secr	etai		d- NI	/Fina bainda				lustry
and	I be fill hall H ad ott	Be	17. Father's Name (First, Middle, La	ist)							(First, Middle,				
Maryland	2 should be and Mental is marked o	ç	Robert R. Gray  19a. Informant's Name/Relationship	o (Type, Print)	19	b. Mailir	ng Address	(Street a			L. Too			tate, Zij	o Code)
	allth a		Bonnie C. Bergst		_						ege Par			740	
ore,	es 1 an of Heal fitem?		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation 3	□ Paraval from Stat	20b. Place cemet	of Dispo	sition (Nam natory or oti	e of her plac	e)	[	Date	20c. L	ocation - C	ity or T	own, State
Ĕ	Pages ment of ant: if it ury or o		4 Donation 5 Other (Spe		Ft. L	inco	1n Cr	emat	tory 9	9/29	/2006	Bren	twoo	d, N	ID
Baltimore,	permit. Pages Department of I Important: if ite any injury or of		21. Signature of Funeral Service Li	censee Mu	lle	22	Name and	Addres inc Slad	oln F ensbu	uner rg R	al Home	ntw	ood,	MD	20722
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus nly one cause on each	ed the death. Do	o not ent	er the mode	of dyin	g, such as	cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	- W	stant St		alococ	ccus	Sept	icen	nia				
	/Medical Examiner		resulting in dealiny		s a consequence	-	-	1							
麓	i da	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Acute  Due to (or a	Chronic s a consequence	e of):	erone	DILLT	LIS					-	
	cuted	Examiner	that initiated events	C -	ratory l		ure	-							
0,	be executed sician and burial-transit		resulting in death) Last		s a consequence										
8760,	icate be ex physician s the burial	dlca		d. Advan	ced Empl	nyse	ma								
Box 6	ath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⅓ No	4☐Pregnant	e of pregnancy 2 Fetal dea at time of death		Ectopic pre						23d. Date Mont		er <b>y</b> Day Year
P.0	by the destached	hys	9 🗆 Unknown	9□ Unknown	A = -385XA		0.000								
Records, F	w requires that been signed I should be det	Completed by P	Part II. Other significant condition Antecedent Myoca	=	_	j in the u	nderlying ca	iuse give	en in Part I.			obacco (	_	_	the cause of death? bably 4 Unknown
eco	e lawre has bee		Pulmonary Hypert	ension							24a. Was autop	sy	pri	or to co	opsy findings available ompletion of cause of
<u> </u>	The I	Con	Cancer of Urinar	y Bladder								rmed? 2 2 No	de	ath? Yes	2□ No
Vital	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h Check only o				
To	ding h. Aftel fune	To	1 Yes 2 No 27. Manner of Death	28a. Date of Ir	iury 28b	Outpatier  Time o		A Bc. Injun	4 🗀 140		me 5 Resident				fy)
on		Certification;	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, L	Day Year)	Injury	М		k? Yes 2⊡I	No					
Division	l or Attendi after death. Director: A I in by the fu	tifle	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of	njury - At home, etc. (Specify)	farm, str	eet, factory,	, office			28f. Location (S City or Tox			or Rur	al Route Number,
Ö	ital or rs after ral Dir led in								10000000000			VIII-10-10-10-1			
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical		xaminer: On the basis and manner	of examination										
	To the vithin To the comple	2	29b. Signature and title of certifier	1 das	i MA				e number	43 (7)			-		Day, Year)
	1		> 5/6/			-		الح ل	12	UL	· .	ンに	41	~	8 2006
	(15)		30. Name and address of person w					v (	lreenh	ne1+	MD 20	0770			
15	St	ate	Shriniuap Rudar 31. Date filed (Month, Day, Year)		Strar's Signature		arkwa	у, С	reent	CIL	2110 21	5110			
223	Regist	rar	OCT 0 3 2006	Klase . M	hour	7						_			

DHMH 17 Rev 1/2001

ORIGINAL

TOD8 12:10a

Please Type or	Print in	Black	Indelible Ink.	Ensure All	Copies A	re Legible
_						

		State of Maryland / Department of Hea	alth and M	ental Hygi	ene			
1- State Registrar Certificate of Death Reg. n2 006 32644								
Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	_			
/Medic	cal	Margaret Evelyn Cushard		Sept.	28, 2006 12:10A M			
Examin	er .	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Lo  Homewood at Crumland Farms  Fred	lerick		4c. County of Death Frederick			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,				
Director		162-12-5596 87 Yrs.	Hours Will.	July 1	9, 1919 PA			
land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits			
Mary Illed	tor	MD Frederick Frederick			1 ☐ Yes 2X No			
ith the Marylar or 28a-f show	Olrec	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?				
s 23a	rai		1703	7 1/2 1/1	USA			
ter de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 2 Never M	Mexican, Puerto I	Rican, etc.)	14. Race - American Indian, Black, White, etc.			
ours at	by	3 TWidowed 4 □ Divorced If Yes, Give Year or Dates:	Specify:		Specify: White			
72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done duri	on ing most of worki	ng 1	6b. Kind of Business/Industry			
within than the	duc	Elementary/Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use retired)  12 homemake	×		own home			
filed Hygi other	Be Co	Tomomore C	B. Mother's Name	(First, Middle, M				
at y fail to Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show imatic event, in Medical Examinational be notified at	To E			Butterb				
Dallillore, Mary failed ZIZIS-DOOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mendal Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. Its Medical Examiner must be notified at once.		Peggy Connor (Granddaughter) 5975 Wescot			City or Town, State, Zip Co2 2315			
1 and 1 and Healt lem 2 other 1		20a. Method of Disposition  1 Solution 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Occupation 3 Deemoval from State 2 Deemoval from			Oc. Location - City or Town, State			
Dallillor Definit, Pages Department of I mportant: If It iny injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Memorial Park	10/1	1 /2006	Undo DA			
Dalli permit. I Departm Importa any inju		/ Itemotitat Italik	of Facility	son Fun	eral Home			
0 82E58	(	31 E. Mai	n St.,	Middle	town, MD 21/69			
		23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, shock, of heart failure. List only one cause on each line.	such as cardiac o		Interval Between			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	umens	Dise	nd Bfrs,			
Examiner					V			
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury						
xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):						
us, F.C. BOX 00/00,  ires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit	cal E	d						
oo rtificat ng phy as the		IF FEMALE.						
ath cer ttendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of delivery  Month Day Year			
he de	ysic	1 □ Yes 2 No 9 □ Unknown 5 □ Other (specify)						
The law requires that the ate has been signed by the page 2 should be detache.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did tob	acco use contribute to the cause of death?			
v requires been sign				1 🗆 Ye	s 2 No 3 Probably 4 Unknown			
taw relay re	Completed			24a. Was an autopsy	prior to completion of cause of			
The				perform 1 Yes 2	ed? death? X No 1 Yes 2 No			
Of VIIAL nec Physician: The law rthis certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?  1   Yes 2   Vo Other: 1   Inpatient 2   ER/Outpatient 3   DOA Other:	6. Place of Death  What was the second secon		nce 6 Other (Specify)			
ding Phys		27. Manner of Pan 28a. Date of Injury 28b. Time of 28c. Injury at Maria		28d. Describe how				
SION tending feath. tor: Afte the fune	atio	Accident investigation M 1 Yes	s 2 No					
or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)			
spital		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time,	date and place, a	and due to the ca	use(s) and manner as stated.			
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ion, death occurre	ed at the time, da	te and place, and due to the cause(s)			
To t To t	Σ	29b. Signature and title of entitier  29c. License n			d. Date signed (Month, Day, Year)			
<u>، ۸</u>		30. Name and address of person who completed gause of death (Item 23a) (Type, Print)	011/		1/20/06			
1,1		30. Name and address of person who completed duse of death (flem 23a) (Type, Print)  The Roberts Kaytwank 300 W 9H 8t. Freda	397/ ersck 1	NO. 21	701			
Sta		31. Date filed (Month, Day, Year) 32. Poistrar's Signature	V					
Registi	rar	OCT 0 3 2006 Alem De April						

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene **David Michael Counts** 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Day October 7, 2006 1225 hrs Medical Examiner David Michael Counts 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 8005 Route 40 Room 234 **Baltimore County** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 212-86-7079 Dec. 30, 1966 39 XM Country) Maryland 2 F Usual Residence of Decedent I0c. City, Town or Location 10d Inside City Limits 10a State iny 1 Yes 2 X No 28a-f show MD Baltimore Parkton items 23a or 28a-f shorust be notified at once. death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20431 York Road 21120 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes Pages I and 2 should be filed within 72 hours after or the fleath and Mental Hygiene.

Int: If item 27 is marked other than "natural", o 4 X Divorced 1 Yes 2 X No specify: Widowed If Yes, Give Year Specify: White 3 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' MD 21215-0036 1 Retail Management Retail Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Katherine Tracey David Monroe Tracey Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Betty J. Lee/Aunt 20431 York Rd., Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place)
Jessop United
Methodist Cemet Oct. 11, 1 X Burial 2 Cremation 3 Removal from State Department of Important: I 2006 Sparks, MD Other Specify Donation 5 21. Signature of Foneral Service Licer 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Cuk 24 Second St., New Freedom, PA 17349 artens Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line /Medical Death Heroin, cocaine, and alcohol intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a X UNPENDED **AMENDED** item#23a,27,28a-f,perME,g860, 10/18/06 TT The law requires that the death certificate be Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed s peen s 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? page ✓ Yes 2 No 1 🗸 Yes 2 No certificate To the Hospital or Attending Physician: 25 Was case referred to medical 26 Place of Death (Check only one) Be, Hospital: 1 examiner? Other Nursing Home 5 Residence 6 Other Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After Certification: Natural 1 Yes 2 y No 5 Pending Fnd 10/7/2006 | Fnd 12:@4 pm ımk Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 8005 Rt. 40 within 24 hours at To the Funeral I found in hotel Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 29c. License numbe O.C.M.E October 8, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registra

			For State Registrar	State of Marylar	-	artmer rtificat			and M		giene eg. No.200	6	32647
	Dhorisi		1. Decedent's Name (First, Middle, Las	t)	,					2. Date of Dea Month		ear	3. Time of Death
	Physicia /Medic	_	AMY	DAVIS						SEPTEM			5:08 A M
	Examin	er	4a. Fecility Name (If not institution, give			4b. City,		Location o			4c. County of [		
			SOUTHERN MARYLA  5. Social Security Number 6. Se		last hirthday)	If Under	CLIN	TON If Under 2	24 Hrs.	8. Date of Birth (Month, Day SEPT I	PRINC		EORGE'S ace (State or Foreign
Н	Funeral Director			□M 2⊠F 93	Yrs.	Months	Days	Hours	Min.	(Month, Day SEPT 1	8 1913 VI	LRGI	NIA
	ט		Usuel Residence of Decedent			1							
	anytar ehow	ž	10a. State 10b. County		ty, Town or Lo							10	d. Inside City Limits 1 1 Yes 2 □ No
	the M	ecto	MD PRINCE  10e. Street and Number	GEORGE'S I	EMPLE	HILLS 10f. Zip					0g. Citizen of Wha	t Count	
	Mith Sa or	Ö	3613 24th AVENUE				20748				U.S.A		.,.
	me 2:	by Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - /		
ဖွ	after or Ite	Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No tf Yes, Give		u res, spe 1 ☐ Yes			, rueno	nicari, etc.)	Specify:	White, e	ACK
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23e or 28e-f ehow La Medical Exam, ar must te notified at	d b	3 🖫 Widowed 4 □ Divorced	Year or Dates:									
15	n 72 nat	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	16a. Deced (Give	dent's Usu <i>kind of wo</i> DO NOT u	rk done a	uring most	of worki	ng	16b. Kind of Busin	ess/Indi	ustry
212	d with piene. r than	шo	Elementary/Secondary (0-12) 7th	College (1-4or 5+)	DO	MESTT	C EN	GINEE	R		PRIVATI	3	
פַ	e filec at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name		Maiden Sumame)		
ylaı	Menta	To	HERBERT L. HITI	<u> </u>				AMIL	'F TO	NI PARH	AM —————		
Maryland	2 sho	3	19a. Informant's Name/Relationship (7			•					, City or Town, Sta		·
e, P	1 and Heelth em 27 ther t		HAROLENA BLAIR/O	GRANDAUGHTER	361 Place of Dispo	-V-4/40/		ENUE		LE HILL	S, MARYLA		
no	ages int of l t: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	natory or c	other place				IVERDALE		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Heelih and Mental Hygiene. Deportment of Heelih and Mental Hygiene.  The mortant: If teem 27 is marked other than "natural; or tieme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen	1				s of Facility			KINS FUN		
ñ	Depermine Depermine Impo		1-L-D. M_	1.011	7	474	LANDO	OVER I			ER, MARYLA		
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the dea									Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	· CEREBRE	VASC	ULA	2 A	*CCI	DEN	T CST	ROKE)		Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						-/		
	LAUIIIIICI	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	DIAL	10	14/2	CTI	2/2			-	
	ted nsit	nine	Cause (Disease or injury	1/A1 21/10 A		Δ0 T	A	ISE	LIF				
Ć.	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec		M	-	1301	. ) 2	_		-	
		icai		d									
89 )	artifica ing ph e as th	Med	IF FEMALE:								l <sub>i</sub>	-	
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feti	aldeath 3□	Ectopic p					23d. Date of Month		y Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of a 9 ☐ Unknown	death 5L	Other (sp	өсту)						•
٥.	The law requires that the death certifica ete has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	bacco use contribu	te to the	e cause of death?
rds	quires an sign									1 🗆 Y	es 2□No 3□	] Proba	bly 4 Unknown
ဝ	e law requir has been si je 2 should l	piet								24a. Was a		e autop	sy findings available
Ě	ding Physician: The lav h. After this certificete has funeral director, page 2	Completed								autops perfor	ned? deat	th?	2⊊No
/ita	ician: Th certificete rector, pag	Be (	25. Was case referred to medicat examiner?						of Death	(Check only or	ie)		
of o	Attending Physician: r death. sctor: After this certifica by the funeral director.	. To	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time of		Othe 28c. Injury	4 🗆 Nui			ence 6 Other (	Specity)	1
Ö	ding th.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	Work	an res 2.∐h		zod. Describe in	ow injury occurred		
Division of Vital Records,	Atten r deal ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of tnjury - At h							treet and Number o	r Rural	Route Number,
ă	s efte	Certification:	4   Nornicide	building, etc. (Speci	ny)					City or Tow	n, State)		
	To the Hospital or Attent within 24 hours efter deatt To the Funeral Director: completely filed in by the	Medical	29a. Certifier (Check only one) Certifying Physics Certifying Physics Certifying Physics (Check only one)	ysician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the c ed at the time, d	ause(s) and manne ate and place, and	r as sta due to	ted. the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and titte of certifier			290	c. License	number		2	9d. Date signed (M	fonth, D	Pey, Year)
	1 - 2		1 /maius	Rour		*	049	3128	2	(	09-26-	- 20	206
HI	t of		30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type,				- 1	41	09-26-		-
			SISOM OSIA,	6193 OXON  Registrar's Sign	HILL R	D#	500	OX	10H	1+1LL	MD 20	174	2.
	Sta Registr		OCT-0 2 2006	100	A CONTRACTOR OF THE PARTY OF TH	Le la							

		1 - For State Registrar	State of Marylan			nt of H te of L		nd Me	ental Hyg	giene Reg. N2 (	006	32648
		1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea	ath		3. Time of Death
Physici		Anthony George Dietz						S	Month eptember	Day 20, 20	Year 006	3:25 A M
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	, Town, or	Location of		1	T- /	unty of Death	
Examili	е.	Montgomery Hospice -			Roo	kville	e			Mor	ntgomery	7
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Unde	r 1 Year	If Under 2		B. Date of Birt	h		nplace (State or Foreign intry)
Director		096-16-7479	M 2□F 88	Yrs.	Months	Days	Hours	Min.	(Month, Da Nug 15			NY
		Usual Residence of Decedent	1 30						iug v _ i			
ylan		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits
Man Man	ţo	MD Montgom	ery S	Silver	Spr	ing						1 Yes 2 No
4 th	Director	10e. Street and Number			10f. Z	p Code				10g. Citizen	of What Cou	untry?
h wit		3126 Gracefield Ro	ad. #304		209	904				USA		
deal	Funerai		Was Decedent Ever in U. Armed Forces?	S. 13. \	Vas Dec	edent of Hi	spanic Orig n, Mexican,	in? (Spec	fy Yes or No		Race - Amer Black, White	
after at Qu		1 ☐ Never Married 2 🔀 Married	1 X Yes 2 □ No If Yes, Give	-		2 <b>X</b> No	Specify:		,			
1213-60036 within 72 hours after death with the Maryland ane. ane. than "natural", or iteme 23e or 28e-1 ehow fra Modical Examplian transition codified at	d by	3 Widowed 4 Divorced	Year or Dates:WWII								ecity: Wh:	ite
72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	kind of w	ork done d	luring most	of working	,		of Business/I	•
Z = 9 = 3	npi	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired					d Stat	
Z Age	ပ္ပ		T	Trader	lld I'K	Exam						Office
Maryland 21215-0036 nd 2 should be filed within 72 hours af the and Mental Hyglene. 27 is marked other than "natural", or traumatic event, the Medical Exami	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (	First, Middle,	Maiden Su	mame)	
Ment Ment	ပ	George Dietz					Mary	y Mar	garet	Kirby		
and and summer	1 3	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Addres	s (Street a	and Number	r or Rural	Route Numbe	er, City or To	wn, State, Z	ip Code)
lore, Maryland 21215-0036 ges 1 end 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If filem 27 is marked other than "natural", or iteme 23s or 28s-1 show or other traumatic event, the Medical Examplaritant to published at		Harriett Grace Die	tz / wife	3126	Grad	efie	ld Roa	ad #3	04, Si	lver	Spring	MD 20904
more, Pages 1 er nent of Hea nt: If item		20a. Method of Disposition		lace of Dispo emetery, crer	sition (Na natory or	ame of other plac	e) [	Da October		20c. Locat	ion - City or 1	Town, State
Pages Pages nent of int: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)		ropolita	ın Cre	matory			006	Alexar	ndria, V	7A
무리 그 원립을	1	21. Signature of Funeral Service License	9 464 1	23	. Name a	nd_Addres	s of Facility	Elmore	al Home,	Tna		
B The B The B		> Hankila Colley	May						t. Silve		or MD 2	20901
		23a. Part I. Enter the disease, or complic	ations that caused the death						•	-	ع تا وا	Approximate Interval Between
		shock, or heart failure. List only on Immediate Cause (Final										Onset and Death
Physician /Medical		disease or condition resulting in death)	Colon Cance								-	
Examiner			Due to (or as a consequ	derice or).								
	2	Sequentially list conditions,	Due to (or as a consequ	uence of):								
led nsit	Ę	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
vision of Vital Records, P.O. Box 68760, Attending Physicien: The law requires that the death certificate be executed death. Cleath. Sector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	uence of):								
8760 sate be e physicien the buria											- 6	
phys	dical	d										
Box 68	by Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	incv						724	Data of doli	
Box eath cert attendin for use	ian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic Other (	pregnancy				230	I. Date of deli Month	Day Year
Ched the de	slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	9a(i) 3[	7 Other (:	spacity)						
P.O. BOX that the death cer ed by the attendir detached for use	문	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause dive	an in Part I		23e. Did t	obacco use	contribute to	the cause of death?
Division of Vital Records, to attending Physicien: The taw requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be d	ð	, and a significant contains on	g.to doubt but not not	g		54450 g	J					obably 4 XUnknown
w requi	Completed									1		
ec law les b	pide								24a. Was autor	an 2	4b. Were au prior to c	topsy findings available completion of cause of
The page	ő								1 Yes	rmed? 2∑No	death?	2 🗆 No
ita itan: artific ctor,	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	one)		
ysic nis ce	2	1 ☐ Yes 2 🖾 No	ospital: 1  Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	Othe Othe	er: 4 🗆 Nur	rsing Hom	e 5 🗆 Resi	dence 6 🔀	Other (Spec	(dy)Hospice
D CD PIG PIG PIG PIG PIG PIG PIG PIG PIG PIG		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f	28c. Injun Work	/ at k?	28	3d. Describe	how injury o	ccurred	
Sath.	atic	2 Accident investigation			M	1 🗆	Yes 2□N	No				
Vis rerde	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, facto	ory, office		28	31. Location ( City or To	Street and N wn, State)	lumber or Ru	ral Route Number,
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:											
ospi hour uner ly fill			ician: To the best of my kno									
To the Hospitel within 24 hours a To the Funeral is completely filled	edical	one)	er: On the basis of examina and manner stated.	non and/or in	- estigatio	лт, пт пт <b>у</b> О	pinon, deat	000011180	a at the time,	uate and pla	ace, and due	to ma cadsa(s)
To the within 2 To the complet	ž	29b. Signature and title of certifier		_	2	9c. License	e number			29d. Date s	igned (Monti	n, Day, Year)
		Cuittin M	William	110	0	HOI	058	03	2	10/1/	2006	
10	1	30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type,	Print)				-,1			MD 20855
		Cynthia M Willia	ms, D.O. , Mc	ntgome	ery F	ospi	ce, 60	001 M	luncast	er Mi	11 Rd.	
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	iture		7	•					
Regist		OCT 0.2 20	06   1	To Ca	ach	,						

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 20, 2006 1550 hrs Deakins Medical Examiner Betty Sue 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lanham (Linton Southern Maryland Hospital Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreian Months Days Hours Director May 11,1951 Country) WV 235-80-0739 55 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 XNo 28a-f show Waldorf MD Charles Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 20601 7021 Evergreen Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married Yes Specify: White Yes Z No specify. Divorced If Yes, Give Year Widowed "natural", \$ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Flementary/Secondary (0-12) Pages I and 2 should be filed within 72 I ment of Health and Mental Hygiene ant: If item 27 is marked other than "I or other traumatic event, the Medical I should be filed within 72 and Mental Hygiene Baltimore, MD 21215-0036 12 Supervisor Restaurant 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Budd Lewis Rosie Martin Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 7021 Evergreen Dr. Waldorf, MD 20601 Larry Deakins/Husband 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/25/06 Nanjemoy, Maryland Department or Important: injury or oth Nanjemoy Baptist Denation 5 Other Specify 21. Signature of Funeral Service Licenses 22. NAREHART ECHOLS FUNERAL HOME, P.A. M00945 Mary's Ave. La Plata St MD 20646 Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line. Between Onset and /Medical Death Cerebral brainstem infarct Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Hypertensive heart disease Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical <sup>AMENDE9</sup>#4b,23a-b,PII,27,perME,g860, 10/30/06 TT attending physician or use as the burial -X UNPENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year Live birth Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ş Yes 2 No 3 Probably 4 🗸 Unknown Chronic obstructive pulmonary disease Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other 4 DOA Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No after death 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certify OCME September 21, 2006 Lonica 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

			For Stata Registrar	State of N	Maryland	-	rtmen tificate			and M		giene	006	32650
	Physici /Medic	al	Decedent's Name (First, Middle Irene     A. Facility Name (If not institution)		Elzey		4h City	Town or	Location o		2. Date of Dea Month Septemb	er 2	Year 8 2006 County of Death	3. Time of Death  12:20 PM M
	Examin Funeral Director		Wicomico Nurs: 5. Social Security Number 220-34-9821	ing Home	Age (In yrs. las	st birthday) Yrs.	If Under Months	Sa.	lisbu If Under	ry _	8. Date of Birt (Month, Day 9-06-1	W	icomico	nplace (State or Foreign untry)
			Usual Residence of Decedent  10a. State 10b. County	comico		Town or Lo								10d, Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a at be noti	al Director	106. Street and Number 105 Oaklee Driv	7e			10f. Zip	Code 826				10g. Citiz	zen of What Co	untry?
980	within 72 hours after death with the Maryland ane. than 'natural', or Items 23a or 28a-f ehow ta Modical Exacilier must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ᠓ Widowed 4 □ Divorced	If Yes Give	s? X No	i	Was Deced f Yes, spec				ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:Whi	e, etc.
Maryland 21215-0036		Completed		nt's Education st grade completed)  College (1-4c	or 5+)	16a. Deced (Give life. L Admin	kind of woi DO NOT us	rk done d se retired,	luring mosi )	t of worki	ng	Reta	nd of Business/l ail Sto: ears	*
ıryland	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, I	To Be C	17. Father's Name (First, Middle, Howard N. Butle 19a. Informant's Name/Relations	er	1	19b. Mailin	ng Address		Cora	J. J	e (First, Middle, Bramble M Route Numbe		Sumame) Town, State, Z	ip Code)
	les 1 and 2 of Health a of Item 27 is		Nancy A. Scott  20a. Method of Disposition  1 Burial 2 Cremation	3 □Removal from Sta	20b. Pla	105 ce of Dispo metery, crem mico N	sition (Nan natory or o	ne of ther place	9)		Land, M.	20c. Loc	826 cation - City or 1	
Baltimore,	permit. Pag Department Important: I any injury o		. 4 □ Donation 5 □ Other (S 21. Signature of Euneral Service		Islo.	22	. Name an	d Addres	s of Facilit	y Bour	nds Fun	era1		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. ASCV	h line.  D as a conseque	ence of):						rest,		Approximate Interval Batween Onset and Death
8760,		ical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseque		RATOI	24	FAIC	uli	,			
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ♥2□ No 9 □ Unknown		n 2 ∏ Fetal d t at time of dea	leath 3	Ectopic pr Other (sp					2	3d. Date of deli Month	very Day Year
	quires that in signed by uld be deta	β	Part II. Dther significant condition ATRIAL FIBI	ons contributing to death	h but not result	ting in the ur	nderlying c	ause give	n in Part I.	•	23e. Did to			the cause of death?
Vital Records,	The ate h	Completed	CVA.										24b. Were aut prior to death? 1 \(\sum \text{Yes}\)	topsy findings available ompletion of cause of
Vita	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	atient 2□El	R/Outpatien	t 3 DC	Othe	r /		n <i>(Check only o</i> me 5 □ Resid		☐Other (Spec	ify)
Division of	ing After une	Certification; T	27. Manner of Death Natural 5 Pendii 2 Accident investi	28a. Date of I (Month, igation		8b. Time of Injury		8c. Injury Work			28d. Describe h			
Divi	ਤੂ ਜੋ ਦੂ ਹ <b>ੂ</b> ਜੋ ਰ		3 Suicide 6 Could 4 Homicide determ	nined 286. Place or building,	Injury - At hom etc. (Specify)						City or Tov	vn, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier Certifyin  (Check only one)  2 ☐ Medical	ng Physician: To the be Examiner: On the basis and manner	s of examination	ledge, death on and/or inv	n occurred vestigation,	at the tim , in my of	e, date an pinion, dea	d place, a	and due to the e ed at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
)	To the within To the Comp	Me	29b. Signature and title of certific	VIA				License 0	number 0631	99.			$\frac{28}{12}$	
\	100		30. Name and address of person Yogesh Vohra	M.D. 614	of death (Item 2 Eastern			Sali	isbur	y MD	21804			
	Sta Registi		31. Date filed (Month Day, Year SEP 2	32. Reg	istrar's Signatu		nack.							

			1 - For State Registrar	State of	Marylar			nt of H				Reg. No.	006	32651
10 m	Physici	an	Decedent's Name (First, Middle, I     TAND A		EMOT	0.77					2. Date of De. Month	Day		3. Time of Death
3	/Medic Examir	al	LINDA 4a. Facility Name (If not institution, g	E.	EMSH	OF.F.	4b. Cit	v. Town. or	Location of		Septemb		8, 2006 County of Deat	
* 3.	Examir	er 	6351 Spring Rdig			08		reder				10.	Freder	
	Funeral	100	Social Security Number 6.			last birthday)		er 1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	hplace (State or Foreign untry)
16E	Director		044-34-7655 Usual Residence of Decedent	IUM ZXIF	64	Yrs.					FEB. 23	, 194	42 Mair	
	yland yow		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Ba-f et	ctor	Maryland Fre	derick		Fred	eric	k						1 ☐ Yes 2 💆 No
	vith th	Funeral Director	10e. Street and Number				10f. 2	ip Code				10g. Citi	zen of What Co	untry?
	eath v	erai	6351 Springridg	e Pkwy/ A			Was Dec	2170		gin? (Sne	ecify Ves or No	Unit	ted Sta	ntes
ထ	after d or Iten	Fun	1 Never Married 2 Married	Armed Force	es? IXINo					, Puerto	ecify Yes or No Rican, etc.)		Black, White	e, etc.
5-0036	ural', c	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Date	es:		1 U Yes	2 <b>∏</b> No	Specify:				Specify: Wh	ite
<u>7</u>	be filed within 72 hours after death with the Maryland Hygiene. Id either than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, Ite Mcciral Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	kind of v	ual Occupa vork done d use retired	turina most	t of worki	ng	16b. Kii	nd of Business/I	Industry
2121	d with	ошо	Elementary/Secondary (0-12)	College (1-4	or 5+)			maker	,			OW	n home	<b>.</b>
p	al Hygie d other event, il	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,	Maiden		
<u>y</u> la	2 should be and Mental is marked o	10	William		An	drews				11ia			White	
Maryland	d 2 sh th and the m traum		19a. Informant's Name/Relationship William R. Emsho										Town, State, Z	
ē,	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		20a. Method of Disposition		1 -	Place of Dispo emetery, crei	sition (N	ame of			ate		MaryLar cation - City or 1	nd 21702 Town, State
altimore,	Pages nent of int: if it	١.,	1 ☐ Burial 2 XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		310	ederick	-			9/30	/2006	Fred	erick.M	laryland
Salt	permit. Pag Department Important: fi eny Injury o		21. Signature of Funeral Service Lic	ensee	1	22	2. Name	and Addres	s of Facilit	y Sta	uffer F	uner	al Home	s, P.A.
· · · · · ·	ĕ o ≡ ē a		Maymond	Tell	rser	\(\frac{1}{2}\)	621 (	)possi	umtow	n Pi	ke/ Fre	deri	ck, MD	21702
10000000000000000000000000000000000000	Physician /Medical		23a. Part 1. Enter the disease, or co shock or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. COT	ona	140		er dying			95e	rest,		Approximate Interval Between Onset and Death
	Examiner				as a conseq	uende of):		- 1						
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events	b. Due to (or	as a conseq	uence of):								
8760,	centificate be executed ding physicien and ise as the burial-transit	Ical	resulting in death) Last	Due to (or	as a conseq	uence of):								
OX O	leath certifica attending ph I for use as t	n/Mec	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of deliv	verv
m	0 00	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown	1 □ Live birti 4 □ Pregnan 9 □ Unknow			□Ectopic □Other (s	pregnancy specify)					Month	Day Year
ecords, F	The law requires that the tee has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying ——	cause give	en in Part I.			bacco u: es 2[		the cause of death?
		Completed									24a. Was autop perfor 1 Yes	sy med?	prior to death?	topsy findings available ompletion of cause of
Vital	ysician: iis certifica	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 □ Inp	ationt O	ER/Outpatier		Othe	_		Check only o	1307		
ō	g Phya ter this neral di	n: To	27. Manner of Death	28a. Date of I		28b. Time of		28c. Injury	at		8d. Describe h		Other (Spec	ify)
200	uttending F death. ctor: After y the funer	atlo	1 Manural 5 ☐ Pending 2 ☐ Accident investigati	on	Day (Bai)	Injury	М	Work	r res 2 🗆 N	No				
Division of	or A	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 25e. Place of	Injury - At he etc. (Specif	ome, farm, str y)	eet, facto	ry, office		2	28f. Location (S City or Tow	treet and n, State)	Number or Rui	ral Route Number,
	To the Mospital or within 24 hours after To the Funeral Discrimpletely filled in	Medical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the bearinger: On the basing and manner	s of examina	wledge, death tion and/or in	h occurre vestigatio	d at the tim in, in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	ause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the crimplet	Σ	29b. Signature and title of certifier		0.1	. ^	2:	c. License	number	li s		29d. Date	signed (Month	, Day, Year)
	/		James &	merener	/Y	1 []		V	36	77	1	0	112917	1006
	(A)		30 Nam an address of derson who	completed cause of	of death (Item	1 23а) ре,	Print)	(iele	(Dr.	#1/	4 Fre	Jos.	ck M.	1 21701
	Sta	te	31. Date filed (Month, Day, Year)	32. eg	istrar's Signa	ture	, 1	100	7		1	and the second		
	Registr	ar	OCT 0 3	2006	we I	O A	28462							

			1 - For State Registrar	State of	Marylar		artment rtificate			and M	ental Hygi	ene g. No.	106	32652
	Physici /Medic		1. Decedent's Name (First, Middle, Las Perry Lynn ERNDE	")							2. Date of Death Month OCTOBER	Day	2006	3. Time of Death  2324 PM
	Examin		4a. Facility Name (If not institution, give	street and num	iber)		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	· · · · · · · · · · · · · · · · · · ·
ă.			Washington County					_	stown			Wa	shingt	on
	Funeral Director		220-16-3739	X XM 2□F	7. Age (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, July 30	,1924	Cour	lace (State or Foreign http) ryland
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Mary!	tor	Maryland Washi	ngton		Hager	stown							1 ☐ Yes 2 🖾 No
	r 28a	lrec	10e. Street and Number			<del></del>	10f. Zip	Code			10	g. Citizen	of What Cour	itry?
	th wit	alD	1124 Kuhn Avenue					217	740			U	ISA	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Item AZ is marked other then "naturel; or items 23a or 28a-f show item AZ is marked other then "naturel; or litems he notilised at other traumatic event, the Medical Examinar must be notilised at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed For 1 XYes If Yes, Give Year or Da	ces?		Was Deced if Yes, spec 1 ☐ Yes 2		ispanic Ori n, Mexican Specify:	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	E	Race - Americ Black, White, Icify: W	
Ş	2 hou	ted	15. Decedent's Ed	cation		16a. Deced						6b. Kind o	f Business/Inc	dustry
218	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of wor DO NOT us	e retired	during mos ()	t of workii	ng			
2	led wi	Con	8	0		asse	mbler	•					blast	ing
	should be fill nd Mental H marked ott	To Be	17. Father's Name (First, Middle, Last) Trebe Ernde								(First, Middle, M Jane Osb		name)	
Man	nd 2 sho lith and I 27 is mu		19a. Informant's Name/Relationship (7) David Ernde - son	ype, Print)			-				Route Number, erstown,	-	-	
ore,	Pages 1 and the sound of the sound into the sound i		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐		State	Place of Dispo	natory or of	her place					on - City or To	
ij	permit. Pages Department of Important: if it any injury or o		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		Kos	se Hill	. Ceme			10/4/				Maryland
Ba	Perm Dep Impo		> Sout/	Ma	nni	17				LI	INNICH F , Hagers			
		П	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that ca	used the deat								Tid: 2	Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	rupt		abdami	200	2017	10 1	ene.	erysm			Onset and Death
£	/Medical Examiner		resulting in death)	Due to (c	r as a conseq	uence of):	1120(				7 3/01			
Н	LXammer	J.	Sequentially list conditions,	b	or as a conseq	uence oti:								
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (c	n as a conseq	derice (ii):								
<u>,</u>	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (c	or as a conseq	uence of):								
8760	ate be hysicia the bur	cal		d										
89	ng ph	Medi	IF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 ∐ Feta	ildeath 3□	Ectopic pre						Date of delive	ry Day Year
o O	The law requires that the death certific tte has been signed by the attending p. page 2 should be detached for use as I	Physician/Medical	1 ☐ Yes Q No 9 ☐ Unknown	4∐ Pregna 9∐ Unkno	ant at time of d wn	eath 5□	Other (spe	ecity)					TOTAL T	Day Tour
J.	res that the de signed by the a l be detached f		Part II. Other significant conditions co	ntributing to de	ath but not res	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did tob	acco use c	ontribute to th	e cause of death?
rds	quires n sign uld be	d by	coronary outer	1 dise	010, 6	Jult	onse	20	lichet	RI	1 ☐ Ye	S €No	3 Prob	ably 4 Unknown
O O	aw require s been sig 2 should b	plete	rollita, Lince	chales.	tereles	MIR.	hio	wic.			24a. Was an		b. Were auto	psy findings available
		Completed	Kidney dispuse								autopsy perform 1 Yes	ed?	death?	npletion of cause of 2□ No
Ī	ctor, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
5	Attending Physician: If death. Sector: After this certification in the funeral director.	၉	1 ☐ Yes 22 No	T	patient				40140		ne 5□Resider			0
ב	tending Ph leath. tor: After th the funeral	lon	27. Manner of Death  Natural 5 ☐ Pending	28a. Date o (Month	n, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	rat ⊲? Yes 2∐!		8d. Describe ho	v injury occ	curred	
181	l or Attendi after death. Director: A	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e, Place	of Injury - At he	ome farm str			185 2		8f. Location (Str.	eet and Nu	mber or Bura	I Route Number
2	after Dire	Certification:	4 ☐ Homicide determined	buildin	g, etc. (Specif	y)	out, raciony	, 011100			City or Town,			, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier Check only one) Certifying Phy	sician: To the laner: On the ba	sis of examina	wiedge, death tion and/or inv	occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, a th occurre	and due to the ca ad at the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
20.0	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c.	License	number	1 1		_	ned (Month,	
			· LA					00	2004	696	10	10-	02-3	1001
			30. Name and address of person who c	ompleted cause	of death (Item	23a) (Type,	Print)	4	,	11	10 mgc/s f			1000
$\mathcal{H}$	8+1		31. Date filed (Month, Day, Year)	NO 1	gistrar's Signa	tenn	54/Va	Ma	Au	_  4	MGC(5+	ميحن	MO.	31147
	Sta Registr		OCT 0 3 2		Callery	A. D	sule	,			٧			

			For State	State of Marylar	•			lental Hygi		00000
			Registrar Amend#11.Pe	rFHPGC 9-28-06	ocr Cer	tificate of	Death			32653
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Wayne	A. Franker	nfield			2. Date of Death Month Sept. 2	Day Year	3. Time of Death 8:35 A <sup>M</sup>
	Examin	-	4a. Facifity Name (If not institution, give National Lut				Location of Death		4c. County of Death Montgon	erv
I	Funeral Director		5. Social Security Number 6. Security Number 18 18	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar • 13,		lace (State or Foreign
	Maryland f show led at	or	Usual Residence of Decedent  10a. State 10b. County Md. Howard	10c. C	ity, Town or Lo	cation :1kridge	1		1	0d. fnside City Limits Y Yes 2 □ No
	h with the 23a or 28e st be notil	Funeral Director	10e. Street and Number 5868- Deborah	Jean Drive		10f. Zip Code 210	75	10	g. Citizen of What Cour	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or Items 23s or 28s-f show any injury or other treumetic event, the Modical Examiner must be notified at once.	by Funer	11. Marital Status  1 □ Never Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces?  1	l I	Vas Decedent of H i Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	thin 72 hours e. en "netural Medical Ex	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give	ent's Usual Occup kind of work done o OO NOT use retired	durina most of worl	king	6b. Kind of Business/Inc	
	filed wit Hyglen other th	Ве Соп	17. Father's Name (First, Middle, Last)	4**	F.	B.I.	18. Mother's Nam	e (First, Middle, M	U.S. Govt	•
Maryland	houtd be d Menta marked metic ev	To B	Arthur A.  19a. Informant's Name/Relationship (Ty	Frankenfie		a Addroce (Stract		ria Rada	baugh City or Town, State, Zip	Contri
	l and 2 s fealth an m 27 is her treu		Mr.Jerry Franke	nfield-Son	5868		h Jean	Dr.,Elk	ridge,Md.	21075
Baltimore,	Pages 1 tment of H tent: if ite		20a. Method of Disposition  1 ☐ Burial 2 🎖 Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Me	cemetery, cren tropol	itan Cr	ematory	-9/24	oc. Location - City or To Alexandri	
Ba	permi Deper Impor any ir		21. Signature of Funeral Service Licens	On an		Name and Address Hyson 3 2222-W	isconsi	n Ave.,	NW,Wash.,	
5	Physician		23a. Part1. Enter the disease, or corposhock, or heart failure. List only a Immediate Cause (Final disease or condition	ne cause on each line.	th. Do not ente	Pres	g, such as cardiac	or respiratory arres	rt,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	SUPSUS	quence of):	1				
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Alexander Hours) that initiated events	Due to (r as a conse	quence of):	l ja	ilung	5		
68760,	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conse	quence of):	Mis	ilur (			
P.O. Box 6	Attending Physicien: The law requires that the death certific r death. r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director, page 2.	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregr 1□Live birth 2 □Fet 4□Pregnant at time of 9□ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
	w requires that t been signed by should be deta	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	nderfying cause giv	en in Part I.		cco use contribute to th	S
Il Records,	: The law requirate has been page 2 should	Completed						24a. Was an autopsy perform	prior to con	osy findings available inpletion of cause of 2 No
<u>≅</u>	ilcien certifi rector	Be	25. Was case referred to medical examiner?	fospital:		Oth		h (Check only one		
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	tion: To	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Specify rinifury occurred	")
Divis	e Hospitel or Attending l 24 hours after death. e Funerel Director: After etely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	the Hospitel nin 24 hours a the Funerel I npletely filled	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as st e and place, and due to	ated. the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	zy, ar	4)	29c. Licens			d. Date signed (Month, $i$ ) $9/23/06$	
2	(12)		30. Name and address of parson who co	ompleted cause of death (Ite	m 23a) (Type, I	Print) 1/01/	A Du	Rockui	9/23/06 11, MD	2
ě	Sta Registr	- 4	31. Date filed (Month, Day, Year)  SEP 2 8 2086	2. Registrar's Sign		Ri		,	, , , , ,	

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	ertment of F	lealth a	and M	F	Reg. No.	32654	
	Physicia	an	1. Decedent's Name (First, Middl	e, Last)						2. Date of Dea Month	ber <sup>25, 2</sup>	3. Time of Death	
	/Medic		Gene Carl	Fusco				1	10 11	Septem			-
*	Examin	er	4a. Facifity Name (If not institution	_	Cerro		4b. City, Town, o		of Death		4c. County of D		
			Annapolis Nu 5. Social Security Number		bilat je (In yrs. la		Annapo		24 Hrs.	8. Date of Birt	Anne Ar	UNCEL Birthplace (State or Foreign Country)	-
	Funeral Director		048-20-8769	1 <b>∑</b> M 2□F	78	Yrs.	Months Days	Hours	Min.	(Month, Da) Apr. 2	<sup>h</sup> Year) 9.	Country) Connecticut	
	D		Usual Residence of Decedent							-			
	arylar	_	10a. State 10b. County		10c. City,	, Town or Lo						10d. Inside City Limits 1 XYes 2 No	
	Ba-f.	Director		Arundel		Ga	mbrills				10g. Citizen of Wha		_
	with the sor 2		10e. Street and Number	Tales Des	" 200		10f. Zip Code	054			USA	Country :	
	eath	era	2610 Chapel	12. Was Decedent	# 208 Ever in U.S	S. 13. V	Vas Decedent of H		igin? (Spe	cify Yes or No-		American Indian,	-
(0	r iten	Funeral	1 Never Married 2 Mar	ned 1 Yes 2 1 If Yes, Give		1				Rican, etc.)		Vhite, etc.	
က် တ	rel', o	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1952-	54	1 ☐ Yes 2 ☐XNo	Specify:	:		Specify:	White	
21215-0036	within 72 hours atter death with the Maryland ene. than "naturel", or Items 23a or 28a-f ahow fra Medical Examirar must be notified at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	st of workin	ng	16b. Kind of Busin	ess/Industry	
7	within ne.	mp	Elementary/Secondary (0-12)	Coffege (1-4or	5+)		nch Chie:			The state of the s	II C Dont	. of Education	71
р Б	Hygie Hygie ther I	ပိ	17. Father's Name (First, Middle,	5+ Last)		ыа	iidi dire.		er's Name	(First, Middle,	Maiden Sumame)	. Of Indication	_
au	ld be ental ked o	To Be	Carlo Fusco					Anı	na Me	nnillo			
Maryland	shou ind M mar	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Numb	er or Rura	l Route Numbe	er, City or Town, Sta	te, Zip Code)	
Σ	and 2 valth a 127 L		Gloria C. Fusa	co / spouse		2610	Chapel 1	Lake 1				s, MD. 21054	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 □Removal from State		ace of Dispo metery, crer	sition (Name of natory or other place	сө)	D	ate	20c. Location - City	or Town, State	
Ě	Pag Iment Iant:		4 □Donation 5 □Other (5	Specify)	Meti	-				-	Alexand		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f ahow any figury or other traumatic event, the Medical Examinating in willish at ADES.		21. Signature of Funeral Service	Licensee	01		Name and Addre		De		neral Home		
	40140		23a, Part1. Enter the disease, o	r complications that cause	d the death		512 NW C					20715 Approximate	-
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each li	ine.		Ann 1/L					Interval Between Onset and Death	
	Physician /Medical		disease or condition resufting in death)	a. Due to (or as	Cuu	ence of):	MYIAX	u/a					-
H	Examiner			500 10 (01 23	a consequ	01100 017.	ı						į
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of).							
	ocuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.									
760,	te be executed ysiclen end le burial-transit	cai Ex	Todaking in Codern Case	Due to (or as	s a consequ	ence or):							
687				d.									
×	The law requires thet the death certifica ate has been signed by the ettending phoage 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date o	f delivery	
Вох	death e etter d for	<u>cia</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			]Ectopic pregnanc; ] Other <i>(specify)</i> _	y 			Month	Day Year	1
P.O.	by the	hys	9 Unknown	9□ Unknown						-			_
	es the igned be de		Part II. Other significant conditi	ons contributing to death t	but not resu	Iting in the u	nderlying cause giv	en in Part	1.		_	te to the cause of death?	
ord	w require been si should I	ted	1991	wo w	INAII	<u> </u>					T	Probably 4 Winknown	
ec	a law has b e 2 st	Completed								24a. Was autop	an 24b. Wer prio prio dea	e autopsy findings available in to completion of cause of	
alF										1 Yes	2 <b>№</b> 1 □	Yes 2□ No	4
Ζ	sicier certif irecto	o Be	25. Was case referred to medical examiner?  1 Yes V No	Hospital:	iont 2 🗆	ER/Outpatier	nt 3 DOA Ott	ner a		Check only o	nne) dence 6 ⊡Other (	Connectivity .	+
ō	Attending Physicien: The lay redath. c death. ector: After this certificate has by the funeral director, page 2.	7: To	27. Manner of Death	28a. Date of Inju		28b. Time o					now injury occurred	Эреспуу	-
ion	ath. er: Aft	atlo	2 (17,00,001)	igation	ay (Gai)	Injury		Yes 2	]No				
Division of Vital Records,	Hospitel or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined   286. Place of in	iury - At hou	me, farm, st	reet, factory, office			28f. Location (3 City or Tox	Street and Number o vn, State)	or Rural Route Number,	
Ω	urs af urs af aral D			A 81									_
	Hospitel 24 hours a Funeral C	edical	29a. Certifier 1 Cartifyi (Check only 2 Madica	Physician: To the best Examiner: On the basis of and manner si	of examinati	wiedge, deat ion and/or in	n occurred at the ti vestigation, in my	me, date <i>a</i> opinion, de	ath occurr	and due to the ed at the time,	date and place, and	er as stated. due to the cause(s)	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of pertif	/			29c. Licen:	se number			29d. Date signed (M	Month, Day, Year)	
			•	+			D.	750	328	3	09-5	26-00	
0	(2)111		30. Name and address of person	who completed cause of	death (Item	-23a) (Type	Print)	· 10 ·	10 1	tooi	10	clic iono Out	1
	C (14	t	Haitya Cho	pra MIL	140	UK	OKICIL	11	VC T	1921	HUNAT	1112 1110 SH	71
	Sta Regist		31. Date filed Month, Day, Yeal SEP 2 8	2006 39 Regist	trar's Signat	ure	ر معر	1			4		
16	riegist	4-1	<b>₩</b>	EUUU KAR		A TEL							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>y</sup>29, 2006 6:30 A. M **Physician** September Eva Cecilia Frv /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 3715 Idolstone Lane Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 16, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Yrs Director 218-74-3533 49 New Jersey Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28e-f shor 1 Yes 2 □ No Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3715 Idolstone Lane 20715 USA Completed by Funeral iral', or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. iled within 72 hours after 1 Never Married 2 Married 1□ Yes 2☐No Saltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced "netural" the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse School Nurse other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bengt Liljeroot Kerstin Rosengren ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 I 3715 Idolstone Lane, Bowie, Maryland 20715 Colin B. Fry - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō = 1 ☐ Burial 27☐Cremation 3 ☐ Removal from State 09-30-06 Department of Importent: If eny Injury or once. Alexandria, Virginia 1 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Pervice Lice. 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic carcinoma 8 months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) has 1 Tes 2 XNo 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2√2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending Injury 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

United Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. Vithin 2 To the 29c. License number 29b. Signature and title of certifier MD D 35/76 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr., Ste. 205, Greenbelt, MD. 20770 Marcia L. Will MD, 31. Date filed (Month, Day, Year) UCT 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Christina Marie E. Fricia

2006 32656

		Registrar					Centific	ale oi	Deall	1				Reg. No.		, ,		200
Physicia dical Exami	an/	1. Decedent's Nam Chris	tina M	arie			a Fric						Date of De Month October	1, 2006	Year		3. Time of E 2045 h	
		4a. Facility Name (i		_					4b. City, T Upper	own, or Lo		Death			County of ince Ge		s	
Funeral Director		5. Social Security N		6. Sex	- Taba	7 Age (In )	yrs last bir		Months	er 1 Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of B		1	Foreigr	1	
		219-04-5 Usual Residence o		1M	2 <b>X</b> F		22	Yrs	-	لبل			OCE.	21,1	1983	Cou	ntry) M	D .
any	ı	10a. State	10b. County			10c.	City, Town	or Locat	ion								10d Inside	City Limits
<u> </u>	ō	MD	Princ	e Geo	orge'	s	Co	olle	ge Pa									2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu 5026 Ire		C+					10f. Zip	<sup>Code</sup> 2074(	n			10g. Citize	en of Wha	at Coun	ry?	
with th ns 23a be noti		11. Marital Status				cedent Ever	in U.S.		as Deceder	nt of Hispa	anic Origin		ofy Yes or N	0- 1	4. Race -		an Indian, E	3lack,
r death or ite	Funeral	1 X Never Marri	_		Armed F Yes Yes, Give Ye	2 <b>X</b>	No		'es, specify Yes 2			чепо к	can, etc.)		White, Specify:		to	
2 hours afte "natural",  Examiner	ρ	3 Widowed  15. Decedent's Ed		or	Dates:		ed) 16a.		Yes 2			nd of wor	rk done		specify: nd of Bus			
11215-0036 Id be filed within 72 hours after fental Hygene narked other than "natural", event, the Medical Examiner	Completed	Elementary/Seco				1-4 or 5+)			ost of wor									
21215-0036 ould be filed within 72 I Mental Hygiene i marked other than ic event, the Medical	dmc	11						Rece	eptio						rinti	ng		
filed Hyg		17. Father's Name								18	_		irst, Middle,		,			
212 Ild be Menta marke	To Be	Mark G			e. Print )	<del></del>	119	b. Mailine	a Address	(Street a			M. To			State	Zin Code)	
and 2 shoulealth and Nearth and N	۲	Mark Gar							Iroq	,			llege				0740	
re, M s I and 2 of Health If item 2 ner traun		20a. Method of Dis	•	n 3	Removal f		20b. Place crema		sition (Nam her place)		etery,	ı	Date	20c. Lo	ocation - (	City or	own, State	
Baltimore, permit Pages I ar Department of He Important: If ite		4 Donation 5	Other S	Specify:			Lakemo						5/2006				lle,	MD.
Baltimore, permit Pages I a Department of He Important: If it in jury or other is	ii.	21. Signature of Fuperal Service Libense 22. Name and Address of Facility Beall Funeral Ho 6512 NW Crain Hwy. Bowie, MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he													715			
Physician		23a. Part I. Enter the failure. List or				caused the o	death. Do n										Approxim	ate Interval Onset and
/Medical Examiner		Immediate Cause or condition resulti	(Final diseas	e a. Mu	ultiple In	juries a consequer	nee of):										D	eath
-		Sequentially list co		b	e to (or as	a conseque	nice or).											
	Examiner	if any, leading to in cause. Enter Under (Disease or high	erlying Cause	Э с		a consequer												
uted 1d ransit	l Exa	events resulting in		d.	e to (or as	a consequer	nce of):											
760, Teate be executed physician and the burial - transit	an/Medical	UNPENDED	)		AMENDED													
68760, ertificate be ding physicie as the buri	n/Me	IF FEMALE: 23b. Was decedent		d	23c. If yes 1 Live	outcome of		_	etal death	3	Ectopic p	oregnand	CY		Date of o	_	ay	Year
P.O. Box 6is that the death cert	sici	past 12 month		alunaum	4 Preg	nant at time	- C -1 - O-		ther (Spec	cify)							•	
D. B. tr the de by the ached f	Phy	Part II. Other sign	_		9 Unki		not resultir	ng in the	underlying	cause giv	ven in Part	t I.	23e. Did	tobacco u	se contrib	ute to t	he cause of	f death?
ires that I signed b	d by				_								1 _ Y	es 2 🗸	No 3	Prob	ably 4	Unknown
Records, The law require	Completed													opsy	pr	ior to c	opsy finding ompletion o	gs available f cause of
ital Recorician: The law scrifficate has lector, page 2 sh	E												1 V Yes	formed? 2 No		eath? ✓ Ye	s 2	No
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case reference examiner?	rred to medic								of Death (C	Check on	ly one)					
Vit hysic this o	일	1 🗸 Yes	2 No	Hos	spital: 1	Inpatient		Outpatien					Home 5		ice 6 🗸		Scene	
Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		27. Manner of Dea	5 Per	nding	Oct 1,	e of Injury th Day Year) 2006		Time of 10 hrs	Injury 2		at Work?	_ in	8d. Describe river auto				n	
Division  To the Hospital or Attent within 24 hours after death To the Finneral Director:	Certification:	2 Accident 3 Suicide	6 Co	estigation uld not be ermined	28e. Pla	ice of Injury				, office bu	ilding, etc.	_	8f. Location or Town,	State)				
lospita 1 hours nneral		4 Homicide 29a. Certifier	7			Major I				time dati	a and plac		oute 4 So					, Upper
To the Hos within 24 h To the Fm	Medical	(Check only one) 2	Medical Ex	aminer: 0		of examina												
F 3 F 3	Me	29b. Signature and	d title of certif		1	1			290	. License	number			29d. D	ate signe	d (Mor	th, Day, Yea	ar)
(3)		CAC	14	N	1	/				O.C.N	1.E.			Octo	ber 2, 2	2006		
ge		30. Name and add			4	use of death			nn Stree	t Baltir	more M	ID 212	01				- SAMARCAS	
	tate					Registrar's S		i i rei	III Stree	a, Daill	note, W	10 2 12		-				
S Regis		OCT 0 3	2006	He			land											

ORIGINAL

			= State Registrar			Certi	ficate of	Death			Reg. No.		0200
			1. Decedent's Name (First, Middle, La	ist)		-				2. Date of De	aath		3. Time of Death
	Physic		Robert	For	d					Septem	ber 28,	2006	2:35 p M
1	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)		4	b. City, Town,	or Location	of Death			ty of Death	<u> </u>
1	Lxamii		Bradford Oak Nur	sing Home			Clinto	n			Prin	ce Ge	orge
	Funeral				(In yrs. last birthe		If Under 1 Year			8. Date of Bir	th	9. Birtho	stace (State or Foreign
	Director			X□M 2□F 3	4 · Yr	s. A	Months Days	Hours	Min.	July	Ž, 1972	Wash	ington.D.C.
			Usuet Residence of Decedent									Wash	ingeon, become
	/land		10a. State 10b. County		10c. City, Town o	r Locat	tion					1	0d. Inside City Limits
	Man	ţŏ	Maryland Prince G	leorges	Temp1	о И-	111c						1 XYes 2 No
	28s	Directo	10e. Street and Number	COLECT	Tempi		10f. Zip Code				10g. Citizen o	f Whal Cour	ntry?
	with or a	ā	5107 Durand Stree	t.				748			Unite	d Sta	tes
	Peath	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Wa			igin? (Sp	ecify Yes or No		ace - Americ	
	tta.	F	Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No					n, Puèrto	ecify Yes or No Rican, etc.)	ВІ	ack, White,	
215-0036	72 hours after death with the Maryland naturel', or ttame 23e or 28e-f ehow disel Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆	Yes 2 No	Specify:			Spec	ify: B1	ack
ŏ	2 hou	ed	15. Decedent's E	ducation	16a. D	eceden	it's Usual Decu	pation			16b. Kind of	Business/In	dustry
15	n n	Completed	(Specify only highest gr		(9)	3ive kin	nd ol work done NOT use retire	a durina mos	st of work	ing			•
212	within jene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) 2		anas	gement	Analy:	st		Priv	ate	
b	filed Hygi Sther ent, I	BeC	17. Father's Name (First, Middle, Last	7)			3			(First, Middle	, Maiden Suma		
an	d be entai	To B	Joseph Michael F	'ord				Eu	faula	Tucke	r		
2	2 should be filed withir and Mental Hygiene. Ie markad other than aumatic evant, the Ma	-	19a. Informant's Name/Relationship		19b. N	lailing A	Address (Stree	nt and Numb	er or Run	al Boute Numb	er, City or Tow	n State Zin	Codel
Maryland	A 60 = 5		Eufaula Stephens	**							ls, Md.	207	
e,	of Health.		20a. Method of Disposition		20b. Place of D	ispositi	on (Name of	-		Date	20c. Location	· City or To	wn. State
ᅙ	Pages nant of int: If it iry or o		1 Burial 2 □ Cremation 3 [				ory or other pla			2006			
altimore,	rtma rtani rtani		4 Donation 5 Other (Special		Harmon						Landov		d.
Bal	permit. Pages Department of Important: If if eny injury or o		21. Signature of Funeral Service Lice	nsee							Homes,		
_	40200		vyune of.	Mari								Maryla	and 20747
П			23a. Part1. Enter the disease, or com shock or heart failure. List only	polications that caused the contract of the co	ne death. Do not	enter t	the mode of dy	ing, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	. A	105								Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence of)	:							
н	Examiner		Conventially list conditions	b									
	-	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	:						, in	
	certificate be executed iding physicien and ise as the burial-transit	Examiner	that initiated events	C.									
ó	exe		resulting in death) Last	Due to (or as a	consequence of)	•							
68760,	te be ysici	/Medical		_ d.									
68	uffica g ph as th	g								-			
ŏ			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- 0-					23d. C	ate of delive	ery
Ď	d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti			topic pregnant ther (specify) _	cy 				fonth	Day Year
P.0.	the cy the	Physicial	9 Unknown	9□ Unknown									
	law requires thet the death c as been signed by the ettenc 2 should be detached for us		Part II. Other significant conditions	contributing to death but	not resulting in th	ne unde	erlying cause g	ven in Part I	l.	23e. Did 1	obacco use co	ntribute to th	ne cause of death?
ds	urres r sign	d by								10	Yes 2 No	3 Prob	ably 4 Unknown
of Vital Records,	w requir been si should	Completed								04- 146-	0.41	141-1-1-1	
š	has ya 2	g D								24a. Was	psy omed?	prior to con	psy findings available mptetion of cause of
=	± at a	ပိ								1 ☐ Yes	2 ₩ No	1 Yes	2□ No
/its	ysician: The is certificate his director, paga	Be	25. Was case referred to medical examiner?	11						(Check only			
5		은	1 ☐ Yes 2 No		2 ER/Outpa		3 DUA	ther: 4 Nu			dence 6 🗆 O		1)
Ē	ding P	e ::	27. Manner of Death  1. Naturat 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju		28c, Inju	ury at ork?		28d. Describe	how injury occi	ırred	
Si O	Attending or death.	ati	2 Accident investigation				M 1	Yes 2	No				
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		· At home, farm (Specify)	, street	, factory, office			28f. Location ( City or To	Street and Nun wn, State)	nber or Rura	l Route Number,
0	rs aff	Cer											
	hou hou unar ity fill	cal	29a. Certifier 1 (X) Certifying P. (Check only 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of e	my knowledge, o	death oc	ccurred at the t	ime, date ar	nd place,	and due to the	cause(s) and r	nanner as si	ated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funaral Director: After the completely filled in by the funeral	Medical	one)	and manner state	d.		nigation, in my	opinion, dea		at tite titile,	uate and piace	, and due to	una cansa(2)
	To Te	2	29b. Signature and title of certifier	144 -				se number	,		29d. Date sign	ed (Month,	Day, Year)
	10			w			56	114			4/2	910	6
_	Lil		30. Name and address of person who	completed cause of dea	th (Item 23a) (Ty	pe, Pri	nt)	0 1 5	) )		T		
	40		Caronne J a	aine 117t	HVIL	rac.	ston 1	Le +	TWI	ashma	sum n	10 2	0)44
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	,							
	Regist	rar	OCT 0 2 2006	Blown 1	1								

			For State of Ma	aryland / D	epartment of Hea Certificate of De	alth and Mental Hydrath	giene () () 6	32658
	Physici	an	1. Decedent's Name (First, Middle, Last)  Belle Louise Farm	rell		2. Date of De. Month	Day th Yeer	3. Time of Death
0	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	- 10	4c. County of Death	1
	Funeral Director		216-22-3554 ¹□м ²\X̄F	ge (In yrs. last birth		Under 24 Hrs. 8. Date of Birliours Min. (Month, Da	th 9. Birth 25, 1925	nplace (State or F <b>DeG</b> n untry) Washington
_	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ahow rmust be neilllied at	ector	MD Charles  10e. Street and Number	I1	ndian Head		10g. Citizen of What Cou	1 ☐ Yes 2 X No
	h with	ai Dir	47 Elder Place		20640		USA	nuy:
1/e	<u>a</u> a <u>a</u>	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Amed Forces?  1 Yes, Given Year or Dates:	,	If Yes, specify Cuban, N	nic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) pecify:	Black, White	
21215-0036	ithin 72 ho ne. nan "natur n Medical i	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or s		Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	ng most of working	16b. Kind of Business/li	ndustry
	filed w Hygier other th	e Cor	17. Father's Name (First, Middle, Last)		Bookeeper 18.	Mother's Name (First, Middle,	H.V.A.C. Maiden Sumame)	
Maryland	Mental Mental arked atic ev	To B	James Franklin Robey		E	dna Robey		
Mar	nd 2 shi lith and 27 is m		John Wyne/Son			Number or Aural Route Number  Upper Marl		
, Z =	of Hea		20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State	20b. Place of cemetery	Disposition (Name of v. crematory or other place)	Date	20c. Location - City or T	Town, State
Baltimore	nit. Pag artment ortent: injury d		4 ☐ Donation 5 ☐ Other (Specify)	Pisgar     10945	n Methodist		isgah,Mar	
B	Den impo		Mavil C. Echul	U943	211 St. M	CHOLS FUNERA ary's Ave. I	L HOME,P. a Plata,M	A. D 20646
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list Immediate Cause (Final disease or condition resulting in death)	ly Ca	incer	uch as cardiac or respiratory ai	rest,	Approximate Interval Between Onset and Death
	Examiner	3,	Sequentially list conditions. b. Deby	a consequence o	EUN			
8760	icate be executed physician and sthe burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	CUT L a consequence o	for the	ve		
P.O. Box 68	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delik Month	very Day Year
	uires that signed t	b	Part II. Other significant conditions contributing to death-b	out not resulting in	the underlying cause given in	1	objecto use contribute to	the cause of death?
Division of Vital Records.	ysician: The law requir ils certificate has been si director, page 2 should	Completed	alidominal	pa	- N	24a. Was autor perfo 1 Yes	osy prior to o ormed? death?	topsy findings available ompletion of cause of
Vita	sician: certific lirector.	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1  Inpatie	ent 2 ER/Out	Other	. Place of Death (Check only of		4.0
ion of	nding Phys ath. r: After this e funeral di	ation; To	27. Manur of Death 1 Natural 5 Pending 2 Accident investigation	ury 28b. Ti	ime of 28c. Injury at hijury Work?	at whether the same of the sam	how injury occurred	ny)
Divis	To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injuried building, et	jury - At home, fan tc. <i>(Specify)</i>	rm, street, factory, office	28f. Location (3 City or Tox	Street and Number or Rui wn, State)	ral Route Number,
	Hospi 24 hou Funer etely fill	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	of examination and	, death occurred at the time, of For investigation, in my opinion	date and place, and due to the on, death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier		29c. License nu	mber	29d. Date signed (Month	Day, Year)
			30. Name and address of person who completed cause of c	death (Item 23a) f	371 <sup>r</sup> Type, Print)	74	11-0/.	2000
S	107		Chon, Song Cenna H	edical	Center 7C	Post Office Rd	. Daldorf, M	C060C
	Sta Regist		31. Date filed (Month, Day, Year) 32. Refistr OCT 0 2 2006	rar's Signature	Speck			

			1 - State Registrar	te of Maryland / Department / Ce	artment of Health and rtificate of Death	Mental Hygier		32659
ı	Physici		Decedent's Name (First, Middle, Last)     Sarah	Goodman		2. Date of Death Month Sept. 2	Pay 2006	3. Time of Death 10:45a.M
	/Medic Examin		4a. Facility Name (II not institution, give street a		4b. City, Town, or Location of De Clinton		4c. County of Death	rges.
\$1. 1.	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday)	If Under 1 Year	rs. 8. Date of Birth	9. Birthpla	ice (State or Foreign
	TO TO		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation	110713031		d. Inside City Limits
	Ba-f eho	Director	D.C	Washing				1 XYes 2 No
	h with th		10e. Street and Number 5008 Meade	St.,N.E.	10f. Zip Code 20019	10g.	Citizen of What Countr	USA
920	togs 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1 M	ned Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 【【No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americal Black, White, et Specify: Blac	tc.
Maryland 21215-0036	a within 72 ho jiene. r then "natur ine wedical	Completed	15. Decedent's Education (Specify only highest grade complete in the complete	llege (1-4or 5+) (Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) Se Wife	vorking	. Kind of Business/Indu	istry
and	id be filed ental Hygic ked other ic event, II	To Be C	17. Father's Name (First, Middle, Last) Charles Clark			ame (First, Middle, Maid rah Smith	ten Sumame)	
Mary	d 2 shou th and M ?7 is marl traumati	-	19a. Informant's Name/Relationship (Type, Pr. Lee Roy Clark / Neph		ng Address (Street and Number or Meade St., N.E. W			Pode)
	Pages 1 an nent of Heal int: if Item 2 iry or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remove	II TOPE STATE	matory or other place)		. Location - City or Tow	
Baltimore,	permit. Pages 1 a Depertment of Hea Importent: If item any injury or othe		4 □ Donation 5 □ Other (Specify)  21 Signature Funeral Service List niee	2	emorial Cem. 9/3 2. Name and Address of Facility J 015 12th ST., N. E	OHN T. RHIN	ES FUNERAL	HOME
			23a Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not en			1	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Oud dore of):	spiratory 7	ailure io varul		Onset and Death
H	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	rive coud	iovarul	as dist	2al
	cate be executed obysicien and the burial-transit	Examiner	that initiated events	Oue to (or as a consequence of):				
8760,	icate be physicie s the buri	dicai	d					
O. Box 6	The law requires that the death certific sie has been signed by the attending p age 2 should be detached for use as	by Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	y Day Year
ds, P.	juires thet i n signed by ild be deta		Part II. Other significant conditions contributi	ng to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
Division of Vital Records,	: The law requir cete has been si page 2 should	Completed				24a. Was an autopsy performed 1 Yes 2	? prior to com	sy findings available pletion of cause of
Vita	ysician s certific director	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	eath (Check only one) Home 5 Residence	6 □Other (Specify)	
on o	Attending Physician: r death. sctor: After this certification by the funeral director.	tion:		Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		
Divisi	i git o	Certification:	3 ☐ Suicide 6 ☐ Could not be	. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural ( tate)	Route Number,
	Mospital 24 hours a Funeral C stely filled	edical C	(Check only 2 Medical Examiner: O	To the best of my knowledge, deal n the basis of examination and/or in id manner stated.	h occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the cause corred at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the within 2	Me	29b. Signature and title of certifier	1 1 D	29c. License number	29d.	Date signed (Month, D.	
. M	(01)		30. Name and address of person who complete	ed cause of death (Item 23a) (Type	Print)		9/26/0 on DC 2	6
/\	Sta	ato	Yudh Gupta	106 Irving St	- NW #415	washingto	on DC 2	0010.
	Registi		SEP 2 8 2006	were & Apon	E)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month Day Year September 30, 2006 **Physician** Lois G. Grimes 6:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Springs Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 15, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 21 F Yrs 1940 Warsaw, 242-62-4011 66 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 77 le marked other than "natural", or Items 23a or 28a-f show treumatic event, the Mudical Examinar must be notified at 1 X Yes 2 ☐ No Director Maryland Prince Georges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8513 Schultz Rd. 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ZNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Senior Member Administrator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 le marked ott Tom Stokes Alberta V. Stallings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8513 Schultz Rd. Clinton, Md. Robert Joseph Grimes / Spouse 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Oct.5, 2006 Washington National Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Genses Alexander S. Pope Funeral Homes, P.A. 20747 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer of the Uterus 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires thet the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12-inonths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si should t 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete hes birector, page 2 s 1 Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖾 No 1∑Inpatient 2☐ER/Outpatient 3☐DOA Certification: To this After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nerel Director: / filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct p. mpletely filled in by 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D51616 September 30, 2006 MP Velsonwale 30. Name and address of person who completed cause of death I tem 23 (Type, Print) Nelson Kalil, M.D. 5454 Wisconsin Ave. Chevy Chase, Md. 20815 S#1300 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 3 2006 Registrar

# 06-07200

Please Type or Print in Black Indelible Ink Terrence Gunnels State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Date of Death Physician/ Dwayne Gunnels Terrence **Medical Examiner** 0325 hrs September 24, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick 5. Social Security Number 8. Date of Birth(MM/DD/YYYY Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 9 Birthplace (State or **Funeral** 451-45-7243 Min 08-2-1978 Director Months Days Hours Country) TX 28  $_{1}\mathbf{X}_{M}$ 2 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits MD Montgomery Gaithersburg or 28a-f show 1 X Yes 2 No Baltimore, MD 21215-0036

permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28af-s sho
righty or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 796 Quince Orchard Blvd. #201 20878 USA ਬੁ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funer Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc. 2 X No Yes Black Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify. è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) Construction Worker Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Wayne Hagger Barbara Gunnels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Bonilla/ Mother 796 Quince Orchard Blvd, #201 Gaithersburg, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-4-06 Silver Springs, MD Gate Of Heaven Donation 5 Other Specify. 22. Name and Address of Facility Taylor's Funeral Home Signature of Euneral Service Licenses 1722 North Capitol St. NW Wash. Part I. Enter the disease, or compl ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on e /Medical Death a Gunshot wound of chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? ✓ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other<sub>4</sub> Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 Other: ဥ 1 V Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject was shot Natural FOUND: death . the f Pending Yes 2 V No Sep 24, 2006 0248 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State determined (Specify) Sidewalk To the Funeral 46 Hamilton Ave., Frederick, MD 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) he, mis O.C.M.E September 24, 2006 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year,

State Registrar

2 2006

0 <u>OCT</u>

06-07169

#### Please Type or Print in Black Indelible Ink

Alfonzo Gwaltney State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) Reg. No Physician/ 2. Date of Death Medical Examiner Month Day September 23, 2006 Alphonzo Gwaltney 0628 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or Director Months Davs Hours 230-08-7383 1 X M 2 F 34 Feb 1, 1972 Country) VA Usual Residence of Deceden any 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 28a-f show MD Wicomico Salisbury 1 XYes 2 hours after death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country 724A Riverside Road 21801 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White etc. Yes 9 3 Widowed Divorced Give Yea Yes 2 X No specify Specify Black ð r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene Comple 12 Warehouse Order Builder Coca-Cola, Inc. other 1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Andrew L. Jones Ida Gwaltney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is r r traumatic B Melissa Y. Gwaltney/wife 724 A Riverside Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, Date 1 X Burial 2 Cremation 3 Removal from State crematory or other place) mportant: Green Acres Mem Park 9/30/2006 Donation 5 Other Specify. Salisbury, MD permit Departm Signature of Furieral Service Licensee 22 Name and Address of Facility
Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part I. Ever the dijlease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval List only cause on each line /Medical Between Onset and a. Gunshot Wounds (2) of torso Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical ysician burial -UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery use as the 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death Pregnant at time of death 5 Other (Specify be detached for 1 Yes 2 No 9 Unknown Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Yes 2 V No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 death? page certificate ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica director, 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other<sub>4</sub> this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes ٤ No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Sep 23, 2006 Natural Subject shot 0215 hrs 5 Pending hours after death Yes 2 🗸 No Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 230 Catherine St, Salisbury, MD determined (Specify) Elks Club 4 Momicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 24, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 Date filed (Month istrar's Signature State 9 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	State of Ma		artment of Health and rtificate of Death	d Mental Hygie	7 11 10	32663
, A	N 4,		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
ı	Physicia /Medic		Robert Clyde Grady	<u> </u>		September	30 2006	6:25 P M
	Examin		ta. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D Westernport	eath	4c. County of Death Allegany	
P		. 4		ome e (In yrs. last birthday)		Hrs. 8. Date of Birth	9 Birthi	place (State or Foreign
	Funeral Director		168-26-3445 1₺\$\mathbb{k}		Months Days Hours	July 12	1931 West	Virginia
(2)	ס	⊢	Usual Residence of Decedent  10a State 10b County	10c. City, Town or Lo	contino			10d. Inside City Limits
	arylar show		10a. State 10b. County Wy. Mineral	Keyser	Cation			1 ☐ Yes 2⁄2XNo
	28a-f	ect	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Cou	ntry?
	3a or		RR 6, Box 6176		26726		United Sta	ates
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam in triust be notified at ance.	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces?  1 1 2 Was Decedent Armed Forces?  1 1 2 Was Decedent Armed Forces?  1 1 2 Was Decedent Armed Forces?		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0036	vithin 72 ho ne. han "natur n Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation e kind of work done during most of DO NOT use retired) Technician	working	b. Kind of Business/Ir Paper Manu	-
d 2	Hygie Hygie other t	ပိ	17. Father's Name (First, Middle, Last)			Name (First, Middle, Mai	iden Sumame)	
an	lid be fental rked c	To Be	Clarence Grady		Max	ry Gowans		
Maryland	nd 2 shou ilth and M 27 Is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Rena Grady/ wife		ing Address (Street and Number of Box 6176, Key	r Rural Route Number, C Yser, West V		
Baltimore,	Pages 1 arent of Heanut: If Item		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)	1 1	c. Location - City or T imberland,	
Balti	permit. Departm Importate any inju		21. Signature of Funeral Service Licensee		2. Name and Address of Facility 111 Church St, V			21562
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list immediate Cause (Final	ne.		Demonti		Approximate Interval Between Onset and Death
le se	/Medical		disease or condition resulting in death)  a. Due to (or as	a consequence of):	Slahenmers	Surger.	,	gins
1967 1988	Examiner	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):				
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
ó	exection and arriginal tr			a consequence of):				
8760,	ate be	lca	d					
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	very Day Year
	uires that signed by lid be deta	Ď	Part II. Other significant conditions contributing to death to	out not resulting in the			cco use contribute to	
Vital Records,	The law require ate has been signage 2 should b	ompleted	/ (			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
ital		BeC	25. Was case referred to medical		26. Place of	Death Check only one		
of V	Physic this ce al direc	10		ent 2 ER/Outpatie		ing Home 5 Residen		city)
ion o	Jing F	atlon;	27. Manner of Feath  T Natural 5 Pending  Accident investigation	ury 28b. Time ay Ye <i>ar)</i> Injury		28d. Describe how	injury occurred	
Division	al or Atta after de: I Directo d in by th	Certification:		ijury - At home, farm, s tc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attanwithin 24 hours after death To the Funeral Director:	edical C	29a. Certifier (Check only one) Scrifying Physician: To the best Check only one) Medical Examinar: On the basis and manner st	of examination and/or i	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the cau occurred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	)	29c. License number		d. Date signed (Month	
			I con	/ .	D2124	+4	10/2/	2006
		4	30. Name and address of person who completed cause of Dr. Jesus Tan, 4 Broadway			1532		
30	St Regist	ate trar	l l l - ソ 2nng 、惑	trar's Signature	Asia,			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No 2 1 1 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 29, 2006 **Physician** 7:30 A M Murray Nathaniel GOLDBERG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health and Rehab Center Montgomery Silver Spring Months Days Hours Min. Feb. 23, Year 915 9. Birthplace (State or Foreign New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15 M 2 ☐ F 079-22-9883 91 Yrs Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County rthen "natural", or Iteme 23a or 28a-f ehow the Medical Exacilmer must be notified at 1 Yes 2 No Montgomery Director Potomac Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 7937 Sandalfoot Drive 20854 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after disperment of Heelth and Mental Hyglene. Important: If Item 27 le marked other then "natural; or Item ony injury or other treumatic event, the Medical Exercitoria. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Plastic Factory/ Elementary/Secondary (0-12) College (1-4or 5+) Businessman/Owner Hote1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Goldberg Bessie Grossman Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Sandalfoot Drive, Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print)
Dr. Stephen Goldberg, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/03/06 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens Olney, MD 21. Signatura | Fune a Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia Years **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending i IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? 1 Yes 2 🔯 No 1 Tes 2□ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 23a Cartifier 1 Cartifying Physician: To the best of my knowledge death conursed at the time, date and plane and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 29, 2006 D 34032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanne P. Asher, M.D., 3720 Farragut Avenue, Kensington, MD 20895-2110 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 32665 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 8:09 P M September Michael Gnatek 28, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Montgomery Suburban Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 € M 2 □ F Yrs 1934 Massachusetts Director April 6, 023-28-1393 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in than "natural", or Items 23s or 28e-f show The Madical Examiner must be notified at 1 ☐ Yes 2 TrNo Maryland Montgomery Kensington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 USA 9531 E. Stanhope Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No HYes, Give 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036
permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural, or Itemeny injury or other treumatic event, the Madical Examination. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates 1955-1958 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Artist Military Historic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Stanley Gnatek Mary Kostek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary G. Harper/ Daughter 9531 E. Stanhope Road, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition October 3, 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. rle 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 Months Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimum actions. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of physicien and s the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death Records, P.O. 9 Unknown ξ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes Ž⁄ ☐ No 3 ☐ Probably 4 ☐Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No certificete 1 Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ⊠npatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2X No 3□ DOA Division of this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 51616 10 September 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Gustavo Neder Kalil, M.D 5454 Wisconsin Avenue, #1300, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 0 2, 2006 Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 27, 2006 8:00PM **Physician** WALLACE TURPIN GARRETT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 117 South Drive Snow Hill Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**M 2□ F 66 221-24-6031 11/25/1939 Delaware Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla nent of Heelth and Mantel Hygiene.

ant: if leave 23e or 28e-f show ant it if the 23e or 28e-f show ant: if the 25e or 28e-f show ant it is the anti-field of the contrastic event, in a hadical Examinant the notified of 1 Yes 2 No MD Worcester Snow Hill Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 South Drive 21863 Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Extension Agent University of MD. 12 8 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Turpin Garrett Marguerite Hastings ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Garrett/ Wife 117 South Drive, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State All Hallows Episc. Cem. 10/4/2006 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, 21. Signature of Fugeral Service Licensee Professional Association, Pocomoke City Dean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinone of Lung 5-11 Cell **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed burial-transi Due to (or as a consequence of): Box 68760, attending physicien for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1) Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one : After this ce funeral dire Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ⊟Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funarei Di completely filled in TIP Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 501.29 2006 230690 M.1. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grall St. Solisburg, MJ 2,801 BA 10 110 145 E. 2 Martin 31. Date filed (Month, Day, Year) 32. Prigistrar's Signature State SEP 2 9 2006 Registrar

1
06-07328
Ricky Herndon

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ Month Day Y September 29, 2006 0825 hrs Medical Examiner RICKY HERNDON 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 11446 Lockwood Drive Apt. 101 Silver Spring Montgomery If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours 1953 Director 578-70-8911 53 Aug. 17, Country) Wash.. Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No 23a or 28a-f show notified at once. Washington DC permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2855 Bladenburg Rd., NE #226 20002 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married Yes **Black** 1 Yes 2 X No specify: If Yes, Give Year Specify Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Flementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Private 9th Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pearlene Herndon Kermit Alexander Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဂ 2855 Bladensburg Rd., NE. #226 Wash., DC Pearlene Herndon/Mother 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10- 6- 06 Beltsville, Md Chesapeake Crematory Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Lice DC 20002 NE Wash. Capitol Mortuary 1425 Maryland Ave. the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one q Between Onset and use on each line /Medical Death Atherosclerotic cardiovascular disease mmediate Cause (Final isease ५xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial - transit Physician/Medical <sup>AMENDED</sup> #23a,27,perME,g860, 10/26/06 TT X UNPENDED Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 3 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? death? funeral director, page ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No 5 Pending the Funeral Director: Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe O.C.M.E. September 30, 2006 Tie 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Pay, Year) 2086 State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Rog. NZ U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Margaret Highsmith September 24,2006 9:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Holy Cross Hospital Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore Months Days Hours Min. March 24,1948 Harrells N.C. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 24 F Yrs 246-82-1789 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar court be notified at 1 XYes 2 No Washington District of Columbia Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 United States 3940 Burns Place SE r deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after dt Ital Hygiene. d other than "natural", or Item 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Š 3 ☐ Widowed 4 🕏 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelth Catholic University Cook None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth eny lolury or other treumatic event ance. Be James Curtis Fennel Doris Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayfield Highsmith Jr/Son 3940 Burns Place SE, Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Keathern Baptist 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 30,2000
22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Licenses 1661 Good Hope Rd SE, Wash DC 20020 Strum 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Hepatorenal Syndrome /Medical Due to (or as a consequence of) Examiner Metastatic Adenocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Deep Venous Thrombosis of Inferior Venacava that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Hepatic failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coagulopath 1 | Yes 2X No 3 | Probably 4 | Unknown Deen 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Nausea and Vomiting autopsy performed? certificete Chronic Pain 1 Yes 2 XN0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 **X**No 1 

☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending heral Director: A 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year) D0055148 September 24,2006 20910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital, 1500 Forest Glen Rd, Silver Spring MD Delroy P Anglin M.D. 31. Date liled (Month, Day, Year) SEP 2 7 2006 2. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Kay R. Hinton 2. Date of Death 9:40A 22,2008 **Physician** Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fort Washington Fort Washington Hospital P.G. 7. Age (In yrs. last birthday). 83 Yrs. If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 579-20-8775 8. Date of Birth (Month, Day, Year) june 10,23 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☑ F Wash., DC. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Temple Hills 10a. State Md. P.G. 10d. Inside City Limits r than "natural", or itams 23a or 28e-f show the Medical Examiner raust be notified at 1 X Yes 2 No **Funeral Director** 10e. Street and Number 2111 Kea 10g. Citizen of What Country? 10f. Zip Code Keating St. 20748 Ŭ.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 end 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Clerk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Navy Department permit. Peges 1 end 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other then any injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First Middle, Last)
Clifford Roberts 18. Mother's Name (First, Middle, Maiden Sumame) Grace Slowe ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2111 Keating St. Temple Hills Md. 20748 <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Carolyn Roberts/ Daughter Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 1 Surial 2 Cremation 3 Removal from State Rock CreekCemetery Sept29,06 Wash., D.C. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Robinson Funeral Home 1313 6th St.N.W. Wash., D.C. 20001 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat, ry arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval B tween Ogsetjan / Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician nemi a use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months Day Month Year 4☐Pregnant at time of death 5 Other (specify) the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use/contribute to the cause of death? Be Completed by 1 Yes 2 👿 No 3 Probably 4 Unknown peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has ormed? 2 V No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes this 28a. Date of Injury (Month, Day Year) 27. Many er of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign ture and title of certifier 29ç. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxi N. Berwa, M. d. 7700 Old Branch Ave. Clinton Md. Suite C101, 31. Date filed (Month, Day, Year) SEP 2 8 2006 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 32670 For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 28, 07:26 September 2006 Robert Hurlock Hambleton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 € M 2 □ F 67 January 8.1939 Maryland Director 214-36-0488 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28e-1 show other traumatic evant. It is Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Ceci1 North East Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö or Items 23a 21901 United States 563 W. Old Philadelphia Road

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after death in nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23s Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 ☑ No f Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Automotive Auto Body Repairman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Irene Hurlock Ernest Joseph Hambleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 563 W. Old Philadelphia Rd., North East, Maryland Barbara Hambleton / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If any injury or once. 2, 2006 Colora, Maryland West Nottingham Cem. rvice Light nsee 22. Name and Address of Facility Crouch Funeral Home 127 South Main St., North East, Maryland 21901 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Box 68760. as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death I ☐Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 2 No 1 ☐ Yes To the Hospital or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ij 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Certification; 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the cau 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title by contifig with completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 2 2006

32. Registrar's Signature

			1 - For State Registrar	State of Marylai	Cei	rtificate of	Death	Re	g. No.	
	Physicia	an	Decedent's Name (First, Middle, Las					2. Date of Deat Month	Day Y	3. Time of Death
	/Medic	al	Arleigh  4a. Facility Name (If not institution, give	Hause:	r	4h City Town	or Location of Deatl		4, 2006	
	Examin	er	209 E. Crook Str			0ak1		11	Garret	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)
	Director		474-10-7293	ØM 2□F 91	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 8,	1915 N	Minnesota
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
	Maryli f eho	5	MD Garret		) Dakland					1X Yes 2 □ No
	28a-	Director	10e. Street and Number	-	Jaklaliu	10f. Zip Code		10	Og. Citizen of Wh	nat Country?
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	D E	209 E. Crook Str	eet		21550			United S	States
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of H	Hispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Race -	- American Indian, White, etc.
9	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No	- 1	1 ☐ Yes 2 X No		,	Specify:	
2-003p	hour tural		3 ₩ Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occur	nation		16b. Kind of Busi	White
Ċ	n "na n "na Nedic	Completed	(Specify only highest gra-	de completed)  College (1-4or 5+)	(Give	kind of work done DO NDT use retire	ation during most of wor d)	rking	100. 141.4 01 040.	
7	d with giene er the	E O	Elementary/Secondary (0-12)	2	Admin	istrativ	e Assista	ant	U.S. Go	overnment
2	al Hy al Hy d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M	Maiden Surname)	
yiana	ould to Ment Markec	2	Herman	Hauser			Viola		Shumway	
Z	12 sh h and 7 is rr freur		19a. Informant's Name/Relationship (7					ural Route Number,		
ກັ	s 1 end 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene "natural", or Items 28a or 28a-f show titem 27 is anxied other than "natural", or Items 28a or 28a-f show other treumatic event, the Medical Examinar must be notified at		Mr. David L. Hau  20a. Method of Disposition		1555 Place of Dispo	sition (Name of matory or other pla	Drive,	Santa Cla		A 91387 ity or Town, State
<u> </u>	ages ent of ht: If I		1 ☐ Burial 2 X Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State		natory or other pla ld Cremat	I	/7/06	Cumberla	and MD
Банитог	permit. Pages 1 end Department of Healt Importent: If Item 2: any injury or other 2		21. Signature of Funeral Service Licen	100.		2. Name and Addre	an of Facility			neral Home
ă	Per la la la la la la la la la la la la la		* Katherine	1 weiter						and, MD 21550
	1019		23a. Part1. Enter the disease, or comp shock, or heart failure. List only		th. Do not ent	er the mode of dyi				Approximate Interval Between
	Physician	W 3	Immediate Cause (Final disease or condition	a Atheroscl	erotio	cardi	ovascul	ar dise	ase	Onset and Death 6 vrs
	/Medical Examiner	:	resulting in death)	Due to (or as a conse	quence of):					
М		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Congestiv Due to (or as a conse	e Hea: quence of):	rt Fail	ure			3½ wks
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
Ç	e exectan an an an an an an an an an an an an a	E	resulting in death) Last	Due to (or as a conse	quence of):					
8/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edicai	(	d						
	certific nding p use as		IF FEMALE:	23c. If yes, outcome of pregr	anov.					4.1.6
X Q	death o	hysician/N	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 🛚	Ectopic pregnanc	у		23d. Date Monti	*
j.	the d by the ached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Ţ	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions or	ontributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
ğ	equire en sig ould b		Hypertension					1 ☐ Ye	ıs <b>2√⊡</b> No 3	Probably 4 Unknown
ပ ပ	12 to 12	Completed						24a. Was ar	y pri	ere autopsy findings available or to completion of cause of
= .	∓ ate	Con						perform		ath? Yes 2 No
N II G	Physician Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#		ath (Check only on		
	d is	٦.	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	IL S DOA	4   Nursing F	lome Reside		
5	nding th. : Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? ∣Yes 2 □No		, ,	
DIVISION	Atter	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	reet, factory, office		28f. Location (Sta City or Town		or Rural Route Number,
5	itel or irs aft rel Dii	Certificati		Sanding, etc. (Open				2., 3. 70	/	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Afte th completely filled in by the funeral		(Check only 2 Medical Exam	vsicien: To the best of my kn iner: On the basis of examin						
	thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	25	9d. Date signed (	Month, Day, Year)
	£ ₹ ₹ 8		Dunald lo	Kilhtin	2	D30			10-04-2	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)				
		10	Donald R. Rich				Drive	Oakland	, MD 2	1550
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4				

DHMH 17 Rev 1/2001

**ORIGINAL** 

			Please I	State of Ma	t in Biad	Dena	rtment of H	lealth and M	II Copies / Iental Hva	eneo o		00670
			1 - State Registrar	Olate of Me	il y laira /	Cer	tificate of	Death		g. No.	06	32672
,	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month October		006 Year	3. Time of Death
3	/Medic	al	Nancy Lucille Hall  4a. Facility Name (If not institution, give				4b. City. Town, o	r Location of Death	October		y of Death	4:15 A M
-	Examin	er	Cherry Hill Assist				Accident			Garre		
	Funeral Director		215-26-0832	7. Age	(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 19	<b>19</b> 30	9. Birthp Cour Mary	place (State or Foreign Tand
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
	a-f eh	ctor	MD Garrett		Accid	lent						1 ☐ Yes 2X No
	with the	Director	10e. Street and Number	ingan Dd			10f. Zip Code			og. Citizen of	What Cour	ntry?
	death The 23s	Funeral	3839 Accident-Bitt	12. Was Decedent B		13. V	21520 Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto			ce - Americ	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturelt, or Items 23a or 28a-f ehow aumatic event, if a MicJost Exaction from the notified at	ρχ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0		Yes, specify Cuba ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Speci	ick, White, <sup>fy:</sup> Whi	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16	(Give I	ent's Usual Occup	during most of work	ang	16b. Kind of 6	Business/In	dustry
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+) N		ng Assis	,		Hospit	al	
2 2	e filed Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)			<u>u </u>		18. Mother's Nam		<del>-</del>		
<u>ya</u>	should be not Mental marked o	To E	Milton Lawrence Ga					Mary Eli				
Mar	s 1 and 2 should f Heelth and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty Danielle Moats/Gra	11.	4			and Number or Rur Bittinger		•		21520
	of Heelth of Heelth f Item 27 r other tra		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of place			20c. Location		own, State
Ē	Pages ment of ant: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					atory Oct	. 4,2006	David	svill	le, PA
Baltimore,	permit. Page Depertment of Important: If any Injury or		21. Signature of Funeral Service Licens	eum	2		Name and Addre	ss of Facility 75, Grant	Newman F sville,		Home 1536	es, P.A.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do	o not ente	or the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
fig.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	end stag			ilure					6 months
	Examiner			Due to (or as: hyperten			ascular (	disease				4 years
	p ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence	e of):	aboutut (	arbeabe				- , , , , , , , , , , , , , , , , , , ,
_	and and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence	e of):					_	
760,	te be executed ysicien and e burial-transit	Ca		d.								
9	ntificate ing phy: a as the	Medi	IF FEMALE:	Chara								
Вох	eath certificate attending phy	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal deat		Ectopic pregnancy Other (specify)	1			ate of deliver	ery Day Year
Р. О	the de by the ached	nysic	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	9☐ Unknown	time of death	5	Other (specify)					
S, D	res that the de signed by the a be detached f	by PI	Part II. Other significant conditions con	ntributing to death be	it not resulting	in the un	derlying cause giv	en in Part I.				he cause of death?
ord	w require been sign		hypertension									pably 4 □Unknown
Division of Vital Records,	The la	Completed	diabetes mellitu	is type tw	0				24a. Was a autops perform	1	were auto prior to co death? 1 \square Yes	ppsy findings available mpletion of cause of
Vita Vita	slcien: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:			om so i Oth	26. Place of Deat er: 4 Nursing Ho	h Check only on			assisted
0	Attending Physicien: r death. ector: After this certifics by the funeral director; 6	n: To	1 Yes 2X No	28a. Date of Injui	nt 2 ER/C	Time of Injury	28c. Injur Wor		28d. Describe ho			facility
Sior	or Attending Ph after death. Director: After th in by the funeral	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(171011111, 04)	, 62.7	injury		Yes 2□No				
Ž	F = -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc		farm, stre	eet, factory, office		28f. Location (St. City or Town		ber or Aura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical C	29a. Certifier Certifying Phy (Check only one)	sicien: To the best of ner: On the basis of and manner sta	examination a	lge, death and/or inv	occurred at the tir estigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mate and place	anner as s , and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of partifier	~		11	29c. Licens		25	d. Date sign	ed (Month,	Day, Year)
,			Mille	Mine	~	mi	2 D0025	5759	0	ctober	2, 2	006
		1	30. Name and address of person who co Walter K. Nauman					P.O. Box	247, Ac	cident	, MD	21520
18. 18. 18. 18. 18. 18. 18. 18. 18. 18.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	K A	103083					
				3/		U 18						

			For Stete Registrar	State of M	arylan	d / Depa	artme <i>tifica</i>	nt of H te of L	ealth ar Death	nd Me	ntal Hygi	ene g. No.	006	32	673
	Physicia	an	Decedent's Name (First, Middle, Last)     STEVEN JAY		BUS					2	Date of Death Month Septembe	1		3. Time	of Death
)	/Medic Examin	al	4a. Facility Name (If not institution, give s	treet and number,					Location of		Эерсешь	4c. C	ounty of Dea	th	, r
		M	6605 HOLLINGSWO  5. Social Security Number 6. Sex			last birthday)		ERWOO er 1 Year	If Under 24	4 Hrs. p	. Date of Birth		MONTGO		e or Foreian
	Funeral Director			M 2□ F	57	Yrs.	Month			Min.	(Month, Day, uqust 2			ennsyl	e or Foreign vania
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							,	City Limits
,	Maryla f sho	ō	Md. Montgom	nery		rwood									es 2 No
	vith the	Director	10e. Street and Number 6605 Hollingswort	h Terrac	e		10f. Z	ip Code	208	55	10	-	en of What Co		
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, the Modical Examinar must be notified at	Funeral		12. Was Decedent Armed Forces 1 ☐ Yes 2 🔀	Ever in U	.S. 13.	Nas Dec f Yes, sp	edent of Hi	spanic Origin, Mexican,	n? (Spec Puerto Ri	ify Yes or No- can, etc.)	1.	4. Race - Ame Black, Whit		,
21215-0036	hours af turai', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		16a. Dece		2⊠ No	Specify:				Specify: d of Business	White	
-612	filed within 72 h Hygiene. other then "nettent, in the Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	(Give	kind of v DO NOT	vork done d use retired	during most o	of working	,				try Co.
	illed w Hygier ther th	Col	12 17. Father's Name (First, Middle, Last)	6		Vic	e Pi	eside		s Name (	First, Middle, M			Indus	try co.
<u>a</u>	Mid be hental red o	To Be		.bus					Vir	gini	a Joh	nsor	n		
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Ty				-				Route Number,	-			
	로드		Marilyn S. Holbus	/ Wife	20h F	6605			vorth	Terr	ace, De		od, Mod. ation-City or		
E 0	00		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	.   .	etropol	natory o	other plac		9/29			exandri		
	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	N. B.	eerl	ier 22	Name Muri P. (	and Address LeI H	s of Facility Barb	er F	uneral aytonsv	Home ille	e, Md.	20882	
1	nysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each	ine. OPHA	GEAL CA	er the m	ode of dyin						Approxir Interval I Onset ar	nate
	cate be executed by physicien and minial-transit on the burial-transit cal Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s al conseq	juance of j:										
P.O. Box 6	The law requires that the death certifi Ne has been signed by the attending age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldeath 3[	Ectopic Other	pregn <i>an</i> cy specify)				2;	3d. Date of de Month	livery Day	Year
ds, P.	uires that t signed by d be deta	d by Ph	Part II. Other significent conditions con	ntributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.			acco us	e contribute t	the cause	
	The law requir ete has been si page 2 should I	Completed									24a. Was ar autops perform 1 Yes 2	y	death?	utopsy findin completion o	gs available of cause of
/ita	Physician: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				Oth	00		Check only on				
o	Phys rthis ral dir	5	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		28b. Time o		28c. Injun Wor	4   19013		e 5⊠Reside 3d. Describe ho			ocify)	
<u>o</u>	Attending in death. ector: After by the funer	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	М		k? Yes 2 ∐ N	0					
Divis	를 를 들	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	ijury - At h itc. <i>(Specil</i>	iome, farm, sti fy)	eet, fact	ory, office		28	If. Location (Sti City or Town		Number or R	ural Route N	lumber,
	To the Hospital within 24 hours a To the Funerei I completely filled	Medical (	29a. Certifier 1 Certifying Phy (Check only one)		of examina										se(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	- 16		1	) [	9c. Licens					signed (Mon		
9			30. Name and address of person who co		Sere death (Iter	m 23a) (Type,	Print)		32407				EMBER	•	
			JOSEPH M. HAGGEF	TY, M.D.	97	707 MED	ICAI	CENT	TER DR	IVE,	ROCKV	ILLI	E, MD.	2085	U
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 0 2, 2	006 32. <b>Bagis</b>	trar's Sign	ature K	Seal								

			1 - For State Registrar	State of Maryla	and / Depa <i>Ce</i>	artment of F <i>rtificate of</i>	lealth and . <i>Death</i>		ien 2005	32674
ľ	Physic	ian	1. Decedent's Name (First, Middle, Last					2. Date of Dea	th	3. Time of Death
	/Medi	cal		amsburg Ho	1ter			Sept.	29, 2006	9:00 P M
	Exami	ner	4a. Facility Name (If not institution, give Homewood at C:		rms		r Location of Deat. erick	h	4c. County of Death Frederic	k
	Funeral	Ė	Social Security Number 6. Se	x 7. Age (in y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		place (State or Foreign
	Director		Usual Residence of Decedent	M 20XF 68	Yrs.	Wiertand Bays	110010 (4111)	Apr. 7	, 1938 MD	
	show		10a. State 10b. County		City, Town or Lo	ocation				IOd. Inside City Limits
	with the Maryland a or 28e-f show	Director	MD Frede	rick	Fre	derick				1 ☐ Yes 2 🔀 No
	= 23 ≡		7401 Willow Ro	d.		10f. Zip Code	21702	1	0g. Citizen of What Cour USA	ntry?
36	after des	y Funerai	11. Marital Status 1 ☐ Never Married 2 🏋 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ★No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: 171	etc.
21215-0036	72 hours "neturel", olcal Ex.	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:					wn	ite
215	be filed within 72 ho ital Hygiene. ed other then "netul event, Ire Modical	Completed	(Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	rking	16b. Kind of Business/In	dustry
21	e filed within all Hygiene. I other then '	Con		College (1-4or 5+) 2		homemake	er		own home	<u> </u>
and	d be fill antal H ed ott	Be c	17. Father's Name (First, Middle, Last)  Mehrle Hench I	Samahura S	r			ne (First, Middle, I	,	
Maryland	2 should be to and Mental I is marked or reumatic eve	70	19a. Informant's Name/Relationship (Ty			ng Address (Street			th Nicoder City or Town, State, Zip	
	ロドト・		Richard Holter		7401	Willow	Rd., F	rederic	k, MD 2170	02
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic QDC8.		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □F	20b semoval from State	p. Place of Dispo cemetery, crer	sition (Name of matory or other place	(e)		20c. Location - City or To	
Itim	artmer ortent: injury		4 □ Donation 5 □ Other (Specify)  21 Sign ture of Fund (Specify)			d cemete			Middletow	
Ba	permii Depar Impol any ir once.	1 8	Must light	_	[ 1	Donald 1 31 E. Ma	B. Thom	pson Fu	neral Home	21769
	*		28a. Part1. Enter the disease, or compli- chock, or heart failure. List only or	ne cause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Que to (oxas a cons	ive su	granucl	ear pa	lsy		Onset and Death
	/Medical Examiner			Due to (ot as a cons	equence of):		1			
	¥-	ner	Sequentially list conditions, if any, leading to immediate each. Enter Ur denying Cause (Disease or injury	Due to (or as a cons	equence of):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
68760,	tificate be executed g physician and as the burial-transit			Due to (or as a cons	equence of):					
687	uficate g phys as the	edical								
Вох	eath certifi attending I I for use as	Physician/M	ZOD. 1423 docoderit programit	3c. If yes, outcome of preg 1□Live birth 2□Fe		Ectopic pregnancy			23d. Date of delive	_
	he dea the al	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant at time o 9□ Unknown		Other (specify)			Month	Day Year
, P.O.	uires that the de signed by the a d be detached t		Part II. Other significant conditions con	tributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to the	e cause of death?
Records,	w requires been sign should be	ed by						1 ☐ Ye	s 2. No 3 Prob	ably 4 🗆 Unknown
ဓင္ပင	e law requ has been je 2 shouli	Completed						24a. Was ar		osy findings available
E B	sician: The certificate hir	Con						perform	ied? death?	2 No
Vital	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital:		Othe		th (Check only one		
of	g Physer this eral di	$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (Specify w injury occurred	")
ion	ttending P death. ctor: After I y the funera	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		<br Yes 2 □ No			
Division	after death after death Director: d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the C	home, farm, stre cify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Rura State)	l Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai C	29a. Certifier ↓☑ Certifying Phys (Check only one)	icien: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	Within To the compl	Me	29b. Signature and title of certifier	`		29c. License	number	29	d. Date signed (Month, I	Day, Year)
)	,		I ful to	Jamos		Do	55061	C	october 2, 2	066
,	8		30 Name and address of person who con	mpleted cause of death (It	W. 9H	Print)	RESIDER		1701	
**	Sta Registra	2	31. Date filed (Month, Day, Year) 0 CT 0 3	2006 Registr 's Sig	nature &	Sporte				

06-07066 Marjorie Jane Hoover

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 32675

		Registrar Certificate of Death		Reg. No.	1000 3207						
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)  Marjorie Jane Hoover	2. Date of Month Septer		Year 1810 hrs						
		As Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  1 Northwood Drive  Timonium  4c. County of Death  Baltimore County									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und			(YY) 9. Birthplace (State or						
Director		578-62-2593 1_M 2XF 55 Yrs. Months Days Hours	Washington, DC								
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
*	ē	Wyoming Albany Laramie			1 Yes 2 No						
<b>21215-0036</b> Uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Director	10e. Street and Number  38 Howe11 Road  10f. Zip Code 82072			What Country? d States						
h with the mrs 23a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American									
ter deatl ", or ite		1 Never Married 2 Married Armed Forces 2 If Yes, specify Cuban, Mexicar 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify		Speci	White						
hours afte 'natural'', Examiner	ed by	15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of	Business/Industry						
5-0036 led within 72   Hygiene other than " the Medical I	Completed	Elementary/Secondary (0-12)  12  College (1-4 or 5+)  5+  Medical Technician	n	Veter	inary Medicine						
ore, MD 21215-0036 s. I and 2 should be filed within 72 hours at of Health and Mental Hygiene If item 27 is marked other than "natural her traumatic event, the Medical Examin		17. Father's Name (First, Middle, Last)  John I. Hoover  18 Mothe Mary	er's Name (First, Mide y Hodgson		ime)						
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental I II: If item 27 is marked other traumatic event,	To Be	19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Nur	mber or Rural Route	Number, City or 1							
, MD and 2 sho ealth and em 27 is		John I. Hoover -brother 14753 Wexhall Term  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	race Burto		, Mary Land 20866						
nore ages 1 ant of Ha		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metropolitan Crematory	9/21/20	06 Alexai	ndria, Virginia						
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	ŀ	4 Donation 5 Other Specify  21. Signature of Funeral Service Licensee  Donald V. Borgy	yardt Fun	eral Home	e, PA e, Maryland20705						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	LL Road Be cardiac or respirator	ettsvitte y arrest, shock, or	heart Approximate Interval						
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Between Onset and Death						
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated									
recuted and rand		events resulting in death) Last  Due to (or as a consequence of):  d									
ਲ ਜ਼ਿਜ਼	dical	X UNPENDED item#23a,PII,27,perME,g860, 10/	/17/06 TT								
18760, tificate be ing physicias the buria	J/Me	FFEMALE: 23b Was decedent pregnant in the   23c If yes, outcome of pregnancy   2   23c If yes, outcome of pregnancy   2   23c If yes, outcome of pregnancy   2   23c If yes, outcome of pregnancy   23c If yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes,	ic pregnancy	23d Date Mont	e of delivery h Day Year						
Box 68 e death cert the attending ed for use a	Physician/Medical	past 12 months?  4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown	, , , , ,								
b.O. But the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part   23e. [	Old tobacco use co	ontribute to the cause of death?						
s, P.O uires that t an signed by 1d be detac	ed b	Rheumatic heart disease			3 Probably 4 Unknown						
Division of Vital Records, tal or attending Physician: The law requir rs after death and Directors. After this certificate has been seled in by the funeral director, page 2 should be	Completed by			autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?						
tal Rec cian: The l certificate			(Check only one)	es 2 No	1 Yes 2 No						
Vita hysicia this ce	To Be	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4	Nursing Home 5		6 Other: Scene						
ion of tending Pheath or: After the funeral		27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Wor 1 X Natural 5 Pending 28c. Injury at Wor 1 Yes 2		ribe how injury oc	curred						
ivisic or Atte after des Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, e		ion (Street and Nu	imber or Rural Route Number, City						
10 P 10 P 1		4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the	cause(s) and mar	nner as started						
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated	occurred at the time,	date and place, ar	nd due to the cause(s)						
_	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.	r		ber 19, 2006						
(18)		30 Name and address of person who completed cause of death (Item 23a)									
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature	21201								
Regis	tate trar	0CT 1 6 2006									

State of Maryland / Department of Health and Mental Hygier 006 32676 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Voar Physician Henry Clinton Jackson September 28. 2006 2:55 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Calvert Manor Healthcare Center Rising Sun 8. Date of Birth (Month, Day, Y Jan. 28, Birthplace (State or Foreign Country) Il Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Months Hours 1**№** M 2□ F 1917 217-03-7890 89 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Maryland Cecil Elkton Direct 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 155 East High Street 21921 ILS.A. 238 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, tems! 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1946-47 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cecil Auto Parts e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Elkton, Maryland Stocked Shelves & Delivered Parts Two Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If Item 27 is marked oth any iqury or other traumatic event ang. Edward Wilmer Jackson, Sr. Margaret Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Atkinson 48 Gilley Road, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hopewell Cemetery 10/02/06 Port Deposit, Maryland 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signay re ol Funeral Service Licensee Lee A. Patterson & Son Funeral H Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final est ono **Physician** disease or condition resulting in death) /Medical onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Examine the burial-transit be executed attending physician and resulting in death) Last Due to (or as a consequence ol): Box 68760 Physician/Medicai 25 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No <u>о</u>. 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Juniown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 Yes 2 3 NO or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and jitle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+IVA 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	artmen tificati	t of He e of D	alth and eath	Mental H	ygienę Reg. No.	006	32677	
			1. Decedent's Name (First, Middle, Las	st)						2. Date of I	Death Day	Yee	3. Time of Death	
	Physicia /Medic		John Donald Jon	es						9	24	200	6 7:35 P M	_
	Examin	7.	4a. Fecility Name (If not institution, give	street and number)					ocation of Deal	th	4c. (	County of De	ath	
	384		Snow Hill Nursin					Hill	L, MD If Under 24 Hrs			rcest		_
-3	Funeral		5. Social Security Number 6. S	ex 7.Ag 12∏ M 2 □ F	e (In yrs. la 87	ist birthday) Yrs.	Months	1 Year Days	Hours Min	. (Month,	Day, Year)		inthplece (Stete or Foreign Country) MD	
ek.	Director	-	214-16-4952 Usuel Residence of Decedent							/	7 1919		riD	-
	M = 1	Ì	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mary	ğ	MD Worces	ter	Sr	now Hi	11						1 ☐ Yes 2 🔀 No	
	728	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What	Country?	
3	38.0		3821 Dogwood Dr.				218	63			US	SA		
	ms 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Deced	dent of Hisp	panic Origin? (	Specify Yes or to Rican, etc.)	No- 1	4. Race - Ar Black, WI	nericen Indian, hite, etc.	
۰	or Ite	교	1 Never Married 2 Married	1 ∑Yes 2 ☐ 1 If Yes, Give	vo Coa	st		2CXNo				Specify: W	hite	
9500-61212	ited within /2 nouts after beam with the waryland. Hydione. Wither than "natural", or Items 23a or 28e-1 show ant, the Modical Examiner must be notified at	d by	3 XWidowed 4 Divorced	Year or Dates:	Gua		Assats Have	1 0				nd of Busines		_
7	nati	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Deced (Give	kind of wo DO NOT u	rk done du	ring most of wo	orking	100. Kii	id Or Busines	samoustry	
7	r than	ď	Elementary/Secondary (0-12)	College (1-4or 5	5+)				Builder		Co	ntraci	tor	
י ס	Hygic Hygic ther	ပိ	17. Father's Name (First, Middle, Last)				F			ıme (First, Midd			COL	
<u>a</u>	fental liked of	To Be	John Edwards Jo	ones					Ethe]	l Brasu	re			
Maryland	d 2 should the and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	(Street ar	nd Number or F	Rural Route Nun	nber, City or	Town, State	a, Zip Code)	
	uith a 27 to r tra		Cheryl J. Adkir	ıs		3821	l Dog	wood	Dr. Sm	w_Fill.	. Md	21863		
ē,	ss 1 and of Healt Item 2		20a. Method of Disposition	Demount from State	CE	ace of Dispo	natory or o	ther place	,	Date			or Town, State	
Ë	Pages nent of int: If It iny or o		1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif		Sun					28/2006				
Baltimore,	permit. Pages of Department of History II Itel Itel any injury or of Otice.		21. Signature of Fundral Service Lices	1500		22	2. Name ar	nd Address	of Facility T	e Burba	age Fu	neraí	Home	
m _	80 <b>E 6</b> 8	112	23a. Part1. Enter the disease, or com	urfal-						Berlin N		11	Approximate	
	All parties of the pa	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Cisease or injury that initiated events resulting in death) Last		o nseque	uence of):	H E	ean bri	t E llati	Dicea ion	re .		Interval Between Onset and Death	2
O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (si				-	23d. Date of 6 Month	delivery Day Year	
ds, P	uires that signed b	þ	Part II. Other significent conditions	contributing to death t	out not resu	ulting in the u	inderlying (	cause giver	n in Part I.		id tobacco u □Yes 2〔	/	e to the cause of death?  Probably 4 Unknown	
Records,	The law require ate has been si bage 2 should t	Completed								24a. W au pe 1 □ Ye	utopsy erformed?/	death	autopsy findings available to completion of cause of ? 'es 2 \sum No	
<u>ita</u>	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place of D	eath (Check on	ly one)			_
<u></u>	Physic this ce al dire	인	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati		ER/Outpatier			4 Nursing	Home 5□R			pecify)	_
0	fing Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury		28c. Injury Work		28d. Descri	be how injur	y occurred		
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerat Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	99 Place of In	jury - At ho tc. (Specify	ome, farm, st	M reet, factor		es 2 No	28f. Locatio City or	n (Street an Town, State	d Number or )	Rural Route Number,	_
	Hospitel of the Hours af Funeral Distriction of the Hours af Distriction of the Hospitel of th	edicai Ce	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of	of examina									
	To the H within 24 To the F complete	Medi	one)	and manner s	tated.			c. License					onth, Day, Year)	_
ı	No To To To To To To To To To To To To To	-	29b. Signature and title of certifier	MM				0 56	,				-06	
•			0	-	d	20 - ) T	-		7466				-06	
	BA2+1		30. Name and address of person who	et St.		ocol		e	/	nd.	218.	51		
-	St: Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signa	K A	Gode	,						

		-	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of artificate o		nd Ment		ne 2006	32678
	Physicia		1. Decedent's Name (First, Middle, Las				<u> </u>		ate of Death	r <sup>Pay</sup> 25 2ŎŨĠ	3. Time of Death 2:35 P м
	/Medic	al	INDIA  4a. Facility Name (If not institution, give	KELLS		4b. City, Town	n, or Location of			4c. County of Death	
	Examin	er	6600 OAK STREE			CHE	VERLY			PRINCE G	EORGE'S
la.	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last birthday 64 Yrs.	/ If Under 1 Ye Months Da		Min. 8. D. (A	ate of Birth fonth, Day, Y 9/1942	9. Birth Cou NOR I	place (State or Foreign intry) H CAROLINA
	pu a		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or I	ocation					10d. Inside City Limits
	Maryla f sho	ō	MD PRINCE G	EORGE'S	CHEVER						1 <b>X</b> Yes 2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip Cod	е		10g	. Citizen of What Cou	intry?
	th with 23a o	alD	6600 OAK STREET			2078	5			U.S.A.	
92	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is merked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Mudical Examinar must be mailling a	y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	,	. Was Decedent of If Yes, specify C	uban, Mexican, I	n? (Specify Y Puerto Rican	es or No- , etc.)	14. Race - Amer Black, White Specify:	
Ö	hours tural',	d be	3 XWidowed 4 ☐ Divorced	Year or Dates:	16a Dec	edent's Usual Oc	cupation		16	b. Kind of Business/li	ndustry
21215-0036	within 72 ane. than "nai	Completed by	(Specify only highest grade completed)    Give kind of work done during most of working life. DO NOT use retired)   College (1-4or 5+)   DATA ENTRY CLERK   PRIVATE								
d 2	filed Hygir other	0	17. Father's Name (First, Middle, Last)		2111	22 22(22)		s Name (Firs	t, Middle, Ma	iden Sumame)	
/lan	Venta	To B	WALTER RAY				MATTI	Е В.	BROWN	1	
Maryland	s 1 and 2 sho of Health and litem 27 is my other traums		19a. Informant's Name/Relationship ( STACEY KELLY/DA			OAK ST				City or Town, State, Zi	ip Code)
Baltimore,	Pages 1 and of He and of Item ant: If item ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control o		20b. Place of Disp cemetery, cr HARMONY	ematory or other	place)	Date /30/200		c. Location - City or T ANDOVER, MA	
Balti	permit. Page Department Important: If any injury or		21. Signature of Funeral Service Licer	-Lall	1	22. Name and Ad 7474 LA				ENKINS FUN R,MARYLAND	
	* ø		23a. Part1. Enter the disease or com shock, or heart failure. List only	olications that cause one cause on each I	d the death. Do not e	nter the mode of	dying, such as ca	ardiac or resp	oratory arres		Approximate Interval Between Onset and Death
125	Physician		Immediate Cause (Final disease or condition resulting in death)	a. METAS	TATIC COLO	N CANCER					Original Death
	/Medical Examiner		Tooding in doday		a consequence of):	C.					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	U.	METASTASI ( a consequence of):	5					
	ocuted nd transit	Examiner	that initiated events	c							
8760,	be executed sician and burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence of):						
687	physics the b	edical	•	d							
O. Box	at the death certificate by the attending phys tached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetaf death 3	☐Ectopic pregna ☐ Other (specify				23d. Date of deli- Month	very Day Year
α.	that the led by the detache		Part II. Other significant conditions of	ontributing to death t	but not resulting in the	underlying cause	given in Part I.		23e. Did toba	cco use contribute to	the cause of death?
rds,	sign d be	ed by							1 🗌 Yes	2⊠No 3∏Pro	bably 4 Unknown
of Vital Records,	The law requeste has been page 2 shoul	Completed							24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
ital	ian: '	Be C	25. Was case referred to medical examiner?				26. Place o		эck only опе)	<u> </u>	-4
∑ <	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		BIT 3 DOA		1		ce 6x Other (Spec	(b) HOSPICE
	After	atlon:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inji (Month, Da	ury 28b. Time ay Year) Injury		njury at Work? 1 □ Yes 2 □ No		Describe how	injury occurred	
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Flace of In	jury - At home, farm, stc. (Specify)	street, factory, off	ice		ocation (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by	edical (			t of my knowledge, de of examination and/or tated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1.	600	29c. Lic	ense number		290	I. Date signed (Month	, Day, Year)
7	(10)		> / conv	askino,			043162		S	EPTEMBER :	26, 2006
K	110)		30. Name and address of person who MELVIN GASKINS	1	death (Item 23a) (Typ. BELLE POI		E GREENB	ELT.MA	RYLANT	20770	
23	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 8 2006		to the						
	ricgisti	ш	AP1 5000	No. of Street, or other Persons	-	-					

			1 - For State Registrar	State of Mar		epartmei Certifica			rental Hy	giene 0	06	32679
	Physici	an	1. Decedent's Name (First, Middle, Last,		1 1				2. Date of De	eath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	John Tyde	en Ketcha		Town or	Location of Death	Septemb	4c. County		5 47 pm
	Examin	er	Doctors Communit				nham	coodion of boath		Princ		orges
	Funeral		5. Social Security Number 6. Set	5 M 2 D E	'In yrs. last birtho	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Feb. 2	th ay, Year)	9. Birthp	place (State or Foreign
	Director		378-34-5159 Usual Residence of Decedent	69	) Yrs	3.			Feb. 2	8, 1937	Mic	higan
~	yland		10a. State 10b. County	1	Oc. City, Town o	r Location					1	0d. Inside City Limits
2	Be-fe	ctor	MD Prince Ge	eorges	Bot	wie						1 TYYes 2 □ No
9	ith with the Marylar 23a or 28e-f ehow	Dire	10e. Street and Number	**		10f. Zi	Code	715		10g. Citizen of V USA	Vhat Cour	ntry?
7	heath ms 23	Funeral Director	3000 Trinity Driv	12. Was Decedent Ev	er in U.S.	13. Was Dece		7/13 ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No		e - Am <i>e</i> rio	an Indian,
111	il Z i 3-0030 within 72 hours after death with the Maryland ene. then natural; or items 23a or 28e-f ehow fra Medical Exactle or ment be inclilled at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:				n, Mexican, Puerto Specify:	Rican, etc.)		k, White, , Whi	
7	72 hours	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(G	ecedent's Usu live kind of w	ork done d	during most of work	ing	16b. Kind of B	siness/Inc	dustry
10	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		torney	ise retired	"		US Go	,¹+	
()	ial y latta & Should be filed and Mental Hygical Branched other summatic event, I	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	710	corney		18. Mother's Name	e (First, Middle			
2	2 should by and Menta is marked aumatic ev	To B		John Clark	k Ketcha	m		Evely	n Tyder	1		
ar	Nical y call of		19a. Informant's Name/Relationship (Ty Claire Bette Ketch			-		and Number or Run				
	Heal Heal Sther		20a. Method of Disposition	iam - wite	20b. Place of Di		-	Drive, Bo	Date	20c. Location -		
etcham	Dallillore, Dermit. Pages 1 ar Department of Hea Important: if Item; Into y Injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	eorge W				0-06	Adelph:	i, Ma	ryland
7, 2	permit. Pages Department of Important: if it eny injury or o		21. Signature of Funeral Service	70 Se	alf			ss of Facility B Crain Hw	eall Fu y., Bow	neral Ho	me /land	20715
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused th ne cause on each line.	ne death. Do not	enter the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,		Approximale Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Hm	yttme	~~					Cristiana Boath
	Examiner		(	Due to (or as a o	consequence of):	tan	1-					
	n =	ner	Sequentially list conditions, flary leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	conseque ce of):	0 - 100	77					
	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):							
05603	sicien buria			4	sonsaquence on.							
-	tificate ng phy es the	fedical		u.								
>	ath cer tendin	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	☐ Fetal death	3 □Ectopic p	regnancy			23d. Da	e of delive	ory Day Year
200	the degraph of the e	Completed by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□ Unknown	ne of death	5 Other (s	oecity)			1410		Day Toal
0	s that	y Pt	Part II. Other significant conditions con	ntributing to death but	not resulting in th	e underlying	cause give	en in Part I.	23e. Did	obacco use cont	ribute to th	ne cause of death?
7	equire equire ould b	ted	Wegerer	viendon	ntons	<u>'</u>			1 🗆	Yes 2□No	3 ☐ Prob	ably 4 Dunknown
000	B law r has be	nple	Chrone 1	level F	almo				24a. Was	an 24b.	Vere auto	psy findings available inpletion of cause of
<u> </u>	n: Th ficete or, peg		25. Was case referred to medical						1 ☐ Yes	2 № No	leath? Yes	2□ No
	ysicie ysicie is certi	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 PER/Outpa	atient 3□ D	OA Othe	26. Place of Deat er: 4 ☐ Nursing Ho		on <i>e)</i> idence 6 ⊟Oth	er (Specifi	v)
1	ng Ph Miter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim	e of	28c. Injury Work			how injury occur		
obiocion of Wital Docoted	ttendi ttendi death. stor: A	Icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	. At home form	M Street factor		Yes 2 □ No	28f Location	Street and Numb	ar or Pur	I Pouta Number
	after after d in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, street, racio	y, omce		City or To	wn, State)	er or nura	r Hodie Number,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Attent his certificate has been signed by the eltending physicien and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of oner: On the basis of each manner state	xamination and/o	leath occurred or investigation	at the time, in my op	ne, date and place, pinion, death occurr	and due to the	cause(s) and ma date and place,	nner as si and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	ı_ A			c. License			29d. Date signe	d (Month,	Day, Year)
			197	m.D.				60545				7, 2006
OR	119		30. Name and address of pege who co	ompleted cause of dea	th (Itam 23a) (Tv	no Print)						
1 //-	112/		ALFIE MINGO	1.d. 5	75 111A	v Sme	£ 7-	50176 3	357 4	AUKEL N	10 0	2701

2. Date of Death

09

Year

2006

Month

	Amend iter
-	Physician /Medical Examiner
	Funeral Director
	pu ,

1. Decedent's Name (First, Middle, Last)

Michael Baron Kyriacos

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAUSBU WICOMICO Cente (es/ova1 Palled PRINCIPALA If Under 1 Year If Under 24 Hrs. 6. Sex / 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 217-38-2617 64 Sept. 15,1942 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28e-f ehov the Medical Examinar must be notified at with the Maryla 1 Yes 2 No Delaware Sussex Rehoboth Beach Direct 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? 302 North Drive 19971 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. nnt: If Item 27 ie marked other then ury or other treumatic event, use Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Tariff Collector Steam Ship Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Olive Gertrude "Norman" Samuel J. Kyriacos 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andreas Pantilic Kyriacos / Brother 935 Oakmoor Drive, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State Department of Important: if any injury or once. Eastern Shore Crematorium 09/29/2006 4 ☐ Donation 5 ☐ Other (Specify) Lewes, Delaware 21. Signature of Euneral Service Licens Parsell Tuneral Homes & Crematorium 202 Laws Street, Bridgeville, DE 19933 Za. Part1. Enter the disease, or concludations that shock, or hear failure. List only one cause on clications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ordinary ACTEMY Days /Medical Due to (or as a consequence of): Examiner DETER DRONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burlaf-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical ettending p use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending within 24 hours efter death.
To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D53551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pine Bluff Rd., Suite 25 Salisbury, m.D 21801 201 James load 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2 9 2006

		1 - For State Registrar	State of Man		artment of I rtificate of		Mental Hygie	2000	32681
Physi /Med		1. Decedent's Name (First, Middle, Last	J	Kinh	, Se	2	2. Date of Death Month	Day Year 2 06	3. Time of Death 1033 M
Exam		4a. Facility Name (If not institution, give Plansua Region a) 5. Social Security Number 6. Se	Medicas C	enter n yrs. last birthday)	4b. City, Town, o	ishury If Under 24-fin		4c. County of Deat	16)
Funera Directo		213-18-4642 Usual Residence of Decedent	Y	7 Yrs.	Months Days	Hours Min	(Month, Day, Ye	919 MAI	hplace (State or Foreign untry) RYLAND
death with the Maryland ms 23a or 28a-f show	50	10a. State 10b. County  MD TALB		C. City, Town or Lo	cation STON				10d. Inside City Limits 1   Yes 2 □ No
r 28a-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	
th witi		38 LONDONDERRY D	RIVE		2	21601		USA	V
_ <u></u>	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Information of Info	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify: WI	e, etc.
Within 72 hours at ene.  Within 72 hours at ene.  The Medical Enerting	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking 16l	o. Kind of Business/	Industry
y y gier 4		12 17. Father's Name (First, Middle, Last)	4	OWNER	FARM SUI			AGRICULT	JRE
Yland  Yland  Jould be fi  Mental H  Harked of  Haric svs:	To Be	DAVIS CLARK KIR				ADA	NAYLOR		
end 2 st end 2 st salth and n 27 is n		19a. Informant's Name/Relationship (T)  JOAN R. KIRBY/WI	•				iural Route Number, C. E., EASTON,		(ip Code)
or the rother		20a. Method of Disposition  1  Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date 200	. Location - City or	
baltimo		21. Signature of Funeral Service Licens		_	. Name and Addre	ss of Facility	N & NEWNAM	RAPPE, MA	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the cause on each line.	201- 2	M C HAL	DICON CT	FACTON M	D 21601	Approximate Interval Between
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	nsequence of):	ry f	21/0	re		Onset and Death
Examine	<u>-</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
sxecuted arecuted al-transit	Examin	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	< 5				
<b>68 / 60,</b> ficate be executed physicien and is the burial-transit	edical E	L.	d						····
DIVISION OF VICAL RECORDS, P.O. BOX of To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours elter death.  To the Funerel Director: Alter this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1⊕Live birth 2 □ 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnance Other (specify)	,		23d. Date of deli Month	very Day Year
uires that to signed by td be detailed	þ	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	_	the cause of death?
ITAL RECOTOS, en: The law requires t	Completed	- Anemia					24a. Was an autopsy	prior to o	topsy findings available
al T		CVIT					performed 1 ☐ Yes 2 ☑	No 1 ☐ Yes	2 □ No
Of VITA Physicien: r this certific ral director.	o Be	25. Was case referred to medical examiner?	lospital: Inpatient	2 ☐ ER/Outpatien	t 3 DOA Ott		ath Check only one)	a (Ta): (a	
g Phy g Phy er this	n; T	27. Manner of Death	28a. Date of Injury (Month, Day Ye		30 000	4 Linuising i	Home 5 ☐ Residence 28d. Describe how i		ify)
sion andin sath. or: Aft	atio	1 Natural 5 Pending investigation	(World), Day 16	par) Injury		Yes 2 □ No			
DIVISION To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	Specify)			28f. Location (Stree City or Town, S	tate)	
hs Hosp n 24 hou he Fune pletely fil	edicai	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of m nar: On the basis of exa and manner stated.	amination and/or in	occurred at the til restigation, in my o	me, date and plac pinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To t To ti	M	29b. Signature-and-life of certifier	1 min		29c. Licens	e number	29d.	Date signed (Month	, Day, Year)
10.11		30. Name and address of person who co	empleted cause of death	ı (İtem 23a) (Type,	Print)	19/168		10/2	100
10+VI		JEFFREY MICHAEL 1 31. Date filed (Month, Day, Year)			ASTERN SE	ORE DRIV	E, SALISBU	RY, MD 21	804
S Regis	tate trar	OCT 0 3 2006	Registrar's	orgnature	10				

			For State Registrar	State of I	Maryland	-	artmen tificat				R	eg. No.	HILL	326	82
ľ	Physici /Medic		1. Decedent's Name (First, Middle, La Ralph Glenn Kelsc								2. Date of Dear October		2006 Year	3. Time of 5:45	Death $\mathbf{P}^{M}$
	Examin	_	4a. Facility Name (If not institution, gir	re street and number	er)		4b. City,	Town, or	Location o	of Death		4c. (	County of Death	)	
	*		251 Aiken-Miller 5. Social Security Number 6.		Age (In yrs. las	t hirthday)	Accid If Under		If Under 2	24 Hrs.	8 Date of Birth		crett	nplace (State o	r Enroian
	Funeral Director			1 <b>⊠</b> M 2□F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day pril 6,	Year) 1916	Col	yland	r Foreign
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	ty Limits
	Pa-f st	ctor	MD Garre	t	Acci	dent								1 ☐ Yes	2 🔀 No
	or 28	Dire	10e. Street and Number				10f. Zip				1	-	en of What Co	untry?	
	eath v	erai	523 Negro Mounta:	In Rd.	nt Ever in II S	12.1	215		enanio Orig	nin2 (Sno	orfu Vac or No	USA	4. Race - Amer	ican Indian	
920	be filed within 72 hours after death with the Maryland the lygiene. All the William and other than "natural", or teme 23a or 28a-f show adonts, the Macheal Examiner must be notified at swent, the Macheal Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? ŠiNo		f Yes, spec		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		Black, White		
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	kind of wor	rk done d	urina most	of workin	na l	16b. Kin	d of Business/l		
2	vithin ne. hen *	np.	Elementary/Secondary (0-12)	College (1-4d		life. L	DO NOT us	e retired)	)						
N	Hyginther ther ant,	e Co	17. Father's Name (First, Middle, Las	1)	A	gricu	Iture	<u> </u>	18. Mothe	r's Name	(First, Middle, I	Farn Maiden S			
$\subseteq$	should be ind Mental marked o	To Be	William Howard Ke								de Glov				
Jan	and and		19a. Informant's Name/Relationship		10		•				Route Number			ip Code)	
d)	1 and 2 Health ism 27 other tra		Virginia Kelso/Wi	rre	20b. Plac	e of Dispo	sition (Nan	ne of	T .		ident,		21520 ation - City or 1	own, State	
altimore,	permit. Pages: Department of the Important: If Its any injury or of once.		1 <b>XXB</b> urial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		te cem	netery, cren	natory or o	ther place			t. 4,20				
	mit. F partme sortan i Injur		21. Signatury of Fune of Service Lice								wman Fu				
ñ	Ted du s		1 Le Zone 1	Kuma		P	.O. B	ox 2	75, 0	Grant	sville,	MD	21536		
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. <u>cancer</u>	ed the death. In line.  Of the as a consequen	e pano		e of dying	3, such as	cardiac or	respiratory arre	est,		Approximate Interval Betwoonset and D 6 month	veen Death
3760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, I any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequer										
P.O. Box 6	The law requires that the death certiticate be executed are has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown		2 Fetal de at time of deat	eath 3	Ectopic pro					23	3d. Date of dein Month	•	'ear
rds, P	w requires that been signed b should be dete	δ	Part II. Other significant conditions	contributing to death	but not resulti	ng in the ur	nderlying ca	ause give	n in Part I.				e contribute to Myo 3 □ Pro		
Division of Vital Records,	rsiclan: The law re s certilicate has bee lirector, page 2 sho	Completed									24a. Was a autops perform	y ned?	24b. Were aut prior to d death? 1 \( \text{Yes}	ompletion of ca	available luse of
Vita	Attending Physiclan: r death. ector: After this certifics by the tuneral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-		(Check only on	<sub>e)</sub>	aiver		
5	Phys ral dii	: To	1 ☐ Yes 2 XNo  27. Manner of Death	1 Inpa	itient 2 EF	VOutpatien  Bb. Time of		^	4 🗆 1901	rsing Hom	le 5 X Reside 8d. Describe ho		<b>Giver</b> Other (Spec	ify)	
0	nding F tth. r: After e tuner	ation	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation		Jay Year)	Injury	м	8c. Injury Work 1 🔲 Y	? ′es 2 □ N	1		, ,			
Divis	를 를 들 드	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home etc. (Specify)	e, farm, str	eet, factory	, office		2	8f. Location (St City or Town		Number or Rui	ral Route Numb	Der,
	To the Hospital or within 24 hours afte To the Funeral Dir completely tilled in	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examination	edge, death n and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	nd due to the ca d at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)	
	To t To tl	Σ	29b. Signature and title of certifier	11	111.0	D		. License			2	9d. Date	signed (Month	. Day, Year)	
}			1/40000	Mus-	, ,	1-2		0025	759 ———		(	Octo	ber 2,	2006	
		3	30. Name and address of person who Walter K. Nauman					i, P.	.О. В	ox 24	47, Acc	iden	t, MD	21520	
	Sta Registr		31. Date filed (Month, Day, Year) OCT = 3	32. Regi	strar's Signatur		Society								

State of Maryland / Department of Health and Mental Hygiene 2006 32683 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 24 2006 **Physician** Lewis 0915 Lucille /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ceci1 E1kton 16 Hatteras Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2XF 24, 1921 85 Maryland Director 219-12-3278 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. fnside City Limits 10c. City, Town or Location 10a State 10b. County worle 7 is marked other than "natural", or iteme 23a or 28e-f ebov traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director E1kton Ceci1 Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 16 Hatteras Court 14. Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) Analyst 12th Government permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, Important: If Item 27 Is marked othe any injury or other trainment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Birdie H. Turner Robert E. Pindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 320 Jefferson St., NW Wash., DC 20011 Monica L. Lewis/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 9/30/2006 Brentwood, MD Stewart Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. En er the disease, or complications that caus, the death, shock, or leart failure. List only one cause on part line. Approximate Interval Between Onse Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cacsa (Final disease or con trion resulting in death) Pnysician /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) physicien a s the burial-P.O. Box 68760, ician/Medical as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached f Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 fnpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; or Attending 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No death 2 Accident filled in by the Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours 1 Tertifying Physician: To the best of my knowledge idealth occurred at the time, date and place and due to the rauso(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's § State Registrar

State of Maryland / Department of Health and Mental Hygiene 006 32684 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month SEPTEMBER 21 2006 4:10 P ARTHUR LUCKETT Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 7 1957 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1[3M 2 F MARYLAND Yrs. 577-78-3227 49 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itame 23a or 28a-f ehow adical Examiner must be confided at 14 Yes 2 □ No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4316 R STREET 20743 death v Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer d Department of Health and Mentai Hygiene. Important: if Item 27 is marked other than "natural; or Itam and Injury or other traumatic event, its Madical Exercised ADEs. Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE WAREHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DOLORES A. SMITH ARTHUR H. LUCKETT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4316 R STREET CAPITOL HEIGHTS, MARYLAND LUCKETT/WIFE LISA 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 9/28/06 CLINTON, MARYLAND 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Priysician /Medical Due to (or as a consequence of) Examiner wall cellulitis Abdomina 1 S. uentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed ng physicien and as the burial-transit mellitue Dlubetes Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Function renal disense 1 Yes 2 No 3 Probably 4 Onknown Gangrenous right toe and foot 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Penphenil Vascular distant 1 Yes 1☐ Yes 2 No or Attending Physician: after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 DNo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide filled 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr Cheverly, UD 20785 State Registrar

OCTOBER

State of Maryland / Department of Health and Mental Hygiene 32686 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) SEPTEMBER 29, 2006 2004 **Physician** JOSEPH BERNARD MASTIN, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 163 N. CONOCOCHEAGUE STREET WILLIAMSPORT WASHINGTON Social Security Number 218-42-3379 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JUNE 13, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 62 1944 Director MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No MARYLAND WASHINGTON WILLIAMSPORT Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 163 N. CONOCOCHEAGUE STREET 21795 U.S.A. or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No UNK • If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced WHITE natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "nat any injury or other treumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) FIRST CLASS MECHANIC TRUCK RENTAL CO. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH BERNARD MASTIN, SR. ELIZABETH CHARLOTTE SCHAUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY L. YATES, SISTER-IN-LAW 150 BRILLIANT STONE DRIVE, MARTINSBURG, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 10/02/2006 SMITHSBURG, MARYLAND `4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Fu 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part . Enter the disease, or complications that cause shock, or heart failure. List only one cause on each complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CONGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner PERCHOL ESTEROLEMIA attending physician and for use as the burial-transit be executed Due to (or as a consequence of P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobação use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. HYPERTEN SION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D53634 leted cause of death (Item 23a) (Type, Print) 11110 MEDICAL CAMPUS RD Beckwit 5H-2+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 2 2006 Coller Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 006 32687 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 09 27 2006 11:07a<sup>™</sup> Theresa Moss /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3210 Norbeck Road, #310 Silver Spring, Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2X F Yrs. 052-30-6612 Rockingham, 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rel', or Items 23a or 28e-f show Examiner must be notified at 1 Yes 2X No Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3210 Norbeck Road, #310 USA 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Black. Specify: Specify þ 3€XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CRS Food Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Bernice McNeil ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Talley/Sister 2051 Merrifield Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 10-02-2006 Silver Spring, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses . Illarshad 4217 9th St NW, Wash. DC 20011 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPERTENSION YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes X No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PULMONARY EMBOLISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? 2 X No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1X Yes 2□ No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 2 | Medic 29d. Date signed (Month, Day, Year) 29b. Signature and title o ertifie September 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAKUL GOYAL, M.D. 3801 International Dr #211, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

SEP 2 9 2006

			1 - State Amend Item	State of Maryland / 28b per ME,G861	Department of I	Health and	Mental Hygie	ne N2006	32688
	Physici	an	Decedent's Name (First, Middle, Last,		Medae	2	2. Date of Death Month	Day Year	
	/Medic	al	4a. Facility Name (If not institution, give	IA YVONNE	MERCER 4h City Town	or Location of Dea		19 06 4c. County of Dea	
	Examir	ier	PRINCE GEORG	/ 0		EVERLY		^	GEORGE'S
A.	Funeral Director		5//-68-9666	7. Age (In yrs. last bi	Yrs. If Under 1 Year Months Days		8. Date of Birth	9. Bir	rthplace (State or Foreign owntry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov					10d. Inside City Limits
	e Mar	Director	MD PRINCE (	GEORGE'S DIST	RICT HEIG	att TS			1 X Yes 2 □ No
	ath with the 23a or 28 uset by no	rai Dire		EVALE AVENU		20147	10g	Citizen of What C	ountry?
36	be filed within 72 hours after death with the Maryland hat Hygiene. ed other than "natural", or items 23a or 28a-f ehow event, I'na Medical Exacinar roust be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	within 72 hou ene. then "netura ne Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work done life. DO NOT use retire	during most of wo	rking 16l	b. Kind of Business	/Industry
22	e filed wat Hygier other the		12. Father's Name (First, Middle, Last)		Office Ass		me (First, Middle, Mai	Private	
lan	should be ind Mental I	To Be	Joseph A. Smith				ine B. Hor	,	
	d 2 sth ar 7 is trau		19a. Informant's Name/Relationship (Ty Amos P. Mercer /		D. Mailing Address (Street 14 Pinevale	and Number or R	ural Route Number, C	ity or Town, State,	Zip Code) 20747
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition  1  Burial 2 Cremation 3  R		of Disposition (Name of ary, crematory or other pla	ce)	Date 200	c. Location - City or	Town, State
ţ	t. Pages rtment of rtant: If it		4 Donation 5 Other (Specify)	Metro	politan		.30,2006 A		
Bal	Depa Impo		21. Signature of Funeral Service Census	ry MOIORS	Alexande 5538 Mar	Iboro Pi	e Funeral ke/Forestv	Homes, Md	·A·20747
).	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	SYSTEMIC INFL	AMMATORY 1				Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequence HOSPITAL ACG	ON: DUIRED PNO	EUMONIA	•		
¥.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	RUIRED PNE ON: FACIAL FRA	0			
	axecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ACIKL TRA	CTURES			
8760,	ate be executed obysicien and the burial-transit	icai	L.	FALL					
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
Division of Vital Records, P	luires that n signed b ild be deta	þ	Part II. Other significant conditions con LIVER FAILURE	tributing to death but not resulting in	n the underlying cause giv	ven in Part I.			o the cause of death?
O O	law requir as been si 2 should	Completed	RENAL FAILURE	ALCOHOLIS	5M		24a. Was an	24b. Were a	utopsy findings available
Ä	The lavelete has pege 2	Com	COAGULOPATHY	THROMBOC	YTOPENIA		autopsy performed 1 ☐ Yes 2 ☑	death?	completion of cause of
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:			ath (Check only one)		
of	Physic this ral dir	<u>٠</u>	1 ✓ Yes 2 ☐ No  27. Manner of Death	1 A Inpatient 2 EH/O	utpatient 3 DOA Time of 28c. Injur	ner: 4 ☐ Nursing F	lome 5 ☐ Residence		icify)
O	nding th: After fune	tion	1 □ Natural 5 □ Pending 2 ★ Accident investigation	(Month, Day Year)	Injury Wor	rk?  Yes 2 🕱 No	FELL 7		EPS
Vis	r Atte er deg rector	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa			28f. Location (Stree City or Town, S	t and Number or R	ural Route Number,
	oitai ours eft urs eft iral Di			1	OME		3514 PINEV	ALE AVE	ISTRICT HGTS MD 20141
	To the Hospital or Attending Physician: The Within 24 hours elter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, pege	edical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowledge ter: On the basis of examination are and manner stated.	nd/or investigation in my o	minion wheth occi	e, and due to the causerred at the time, date	and place, and due	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1)	29c: Licens	e number	29d.	Date signed (Mont	
	(14					46937		9-23-	06
	Uge		30. Nime and address of person who co DR GABRIEL KYE	3001 +	(Type, Print) toSPITAL 2	DR	CHEVERLY	, MD c	20185
	Sta Registr	te ar	SEP 2 7 2006	32. Renistrar's Signature	,			,	

			1 - For State Registrar	State of Maryland	/ Depa	irtment <i>tificate</i>	t of He e of D	ealth a <i>eath</i>	nd Me		gienez Reg. No.	006	328	589
	Physicia		Decedent's Name (First, Middle, Last)  James Lee Mudd	l. Sr.						Date of Dea Month eptemb		, 2006	3. Time o	of Death A M
	/Medic Examin		4a. Fecility Name (If not institution, give st			•		ocation of		<u>_'</u>	4c. C	ounty of Death		
	Funeral		Suburban Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under		If Under 2		. Date of Birt	h	ntgome 9. Birth	place (State	or Foreign
	Director		217-28-2087	<sup>M 2□ F</sup> 72	Yrs.	Months	Days	Hours	Min. A	ug. 17		4 Was	ningto	n DC
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside C	ity Limits
	he Mar 8a-f el	Director	Maryland Charles	Po	rt To						10 000	()4# + 2		\$ <b>3</b> ∕□ No
	death with the Maryland me 23a or 28a-f ehow r must be notified at	I Dir	7770 Penn Manor Ct			10f. Zip		677			iog. Citize	on of What Cou	ntry ?	
٥	o 72 hours after death with the Marylan "neturel", or Iteme 23a or 28a-f ehow idical Examiner must be notified at	/ Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes. Give		Vas Deced Yes, spec		panic Orig , Mexican, Specify:	jin? (Speci Puerto Ri	fy Yes or No- can, etc.)		Race - Amer Black, White	etc.	
3-003p	"neturel", adical Eve	ed by	3 ☐ Widowed 4 X Divorced  15. Decedent's Educ	Year or Dates:	16a. Deced	lent's Usua	I Occupat	ion				of Business/l	White	
212	within 72 hours after ene. then "neturel", or ite he Medical Examina	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of wor OO NOT us	rk done di. e retired)	iring most	of working				,	
V	Hygi Hygi ther int,	e Con	12 17. Father's Name (First, Middle, Last)		Fire	Techr			r's Name (	First, Middle,		nty Gov <sub>umame)</sub>	ernmen	ıt
/land	uld be Vental Irked o	To Be	James Jarboe Mudd	/ Secretary						Manni				
Mar	12 sho h and I 7 le mu traume		19a. Informant's Name/Relationship (Typ	e, Print)		-					-	Town, State, Zi		
<u>ē</u>	item 2	1 19	Brian Mudd - Son  20a. Method of Disposition		ce of Disponetery, cren	sition (Nam	ne of		Dai 0-5-0	10		ation - City or T		
altimor	Page tment tant: If jury or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Re	esurre	ectio	n Cen	neter	У			con, MD		
ga	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		21. Signature of Euneral Service Licenses  Task A. W.	Ks→ M01246		. Name and Intt F						hingto dorf,		04
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. cause on each line.  Lung Cancer (  Due to (or as a conseque	Squam						rest,		Approxima Interval Be Onset and One MO	tween Death
9,00,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially lifet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque										
O. Box 6	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnanc 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3	Ectopic pre					23	d. Date of delivership		Year
<u>,</u>	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions cont Pathologic fractur			nderlying ca	ause giver	n in Part I.			obacco use /es 2 🗆	e contribute to	the cause of bably 4	
Hecords	law as b	Completed	Ischemic cardiomyo							24a. Was autop		24b. Were aut prior to o death?	opsy findings ompletion of	available cause of
Vital	ician: The certificete h rector, page	0	Chronic obstructiv	e pulmonary di	isease	<u> </u>		26 Place	of Death /		2 <b>X</b> No	1 Yes	2 <b>∑</b> No	
O TO	W 17	To B	examiner? 1 ☐ Yes 2 💢 No	spital: 1 ፟ Inpatient 2 ☐ EF	VOutpatien		A Other	4 □ Nur				□Other (Spec	fy)	
_	or After	tlon:	27. Manner of Death 1	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	M 21	8c. Injury Work?	at ? es 2 ∐ N		d. Describe h	now injury	occurred		
DIVISION	ne Hospital or Attending n 24 hours after death. ne Funerel Director: After pletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre					f. Location (5 City or Tox		Number or Ru	al Route Nur	nber,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	Medical C	29a Certifier 1 1 Certifying Physic (Check only one)	orian: To the best of my knowledge: On the basis of examination and manner stated.	edga, daeth n and/or inv	estigation,	at the twic	date and nion, deat	h occurred	d this to the lat the time,	date and p	nd makinar as lace, and due	stated to the cause(	s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  Michael &	Westerman	M.D		License			-		signed (Month ember 3		)6
0	811		30. Name and address of person who com Michael A. Westerm	•			town	Road	. Bet	hesda.	MD 2	20814		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signatur	re				, = 0 0					

State of Maryland / Department of Health and Mental Hygieney 32690 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 28 2006 CATHERINE MUTH 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHAB. CENTER BERLIN WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F 87 Yrs. Director 216-28-5931 5, 1919 MARYLAND Usual Residence of Decedent 10b Counts 10a State 10c. City, Town or Location 10d. Inside City Limits Show Director 1 ☐ Yes 2 X No MARYLAND WORCESTER OCEAN CITY the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2 culner count be o 9844 KEYSER POINT ROAD 21842 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No r then "natural", o Specify. 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 7 le marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Mental JOSEPH ဥ TILLERY CHRISTINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if item 27 le ury or other trai CATHERINE T. MAASKANT/DAUGHTER 37169 HUDSON ROAD, SELBYVILLE, DE. 19975 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. CREMATORY OF DELMARVA 4 □ Donation 5 □ Other (Specify) 9/29/06 DELMAR, DELAWARE 21. Sig/ ture / Funer Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on 23a, Part1. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ardio vasculer hooselerotee euce /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ been si Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has of Vital 1 ☐ Yes 283 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: of or Attending Fath. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ont 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) Coastal Hylury 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Catherine

		-	For Stete Registrer		State of M	laryland		artment of H tificate of L		Reg	g. No.	106	32691
	Physicia	an	1. Decedent's Name	(First, Middle, Las	t)					2. Date of Death Month Septembe		Year	3. Time of Death
E	/Medic	al	Ivan Edga			1		4h City Town or	Location of Death	Septembe	Υ	2006 nty of Death	9:10 A <sup>M</sup>
	Examin	er	Goodwill			,		Grantsvi.			Garr		
	Funeral Director		5. Social Security Nur 215–12–230	mber 6. Se	117.11	ge (In yrs. Ia 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 4,			place (State or Foreign ntry) Land
	pu *		Usual Residence of D	Decedent 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
	Aaryla r ahov	ō		Garrett			tsvill					į	1 X Yes 2 □ No
	the A	Director	10e. Sfreet and Num			GLan	CSVIII	10f. Zip Code		10	g. Cifizen o	of What Coul	ntry?
	3a or	<u>a</u>	191 Ravir	ne St.				21536			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Department of Heelth and Mental Hyglene. Importants if item 27 is marked other then "natural", or iteme 23a or 28a-f ahow amportants if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow amportants it items it is marked in a mortal barnotified at an ances.	by Funeral	11. Marital Status  1 Never Marrie  3 Widowed 4		12. Was Decedent Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates:	? 1 No		Was Decedent of Hi if Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? (Sp. In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	В	Race - Americ Black, White, city: Whit	etc.
5-0036	tural sal Ex	edt		15. Decedent's Ed	ucation	- 1111 2	16a. Dece	dent's Usual Occupa	ation	1		Business/In	
212	nin 72	Completed	(Specif	y only highest gra	de completed) College (1-4or	5+)		kind of work done of DO NOT use retired	during most of work f)		<b>3</b>	l	
2121	giene grene er the	E	8	dary (0.12)	College (1 4cl	0.,	Self-	-Employed				le Mach	nines
p	be file tai Hy d oth	Be	17. Father's Name (F							e (First, Middle, M		name)	
<u>Y</u>	should be land Mentail le marked o	ျှ	Wilson E.				405 14-12	ng Address (Street a		isenmill		- State 7	- Codol
Maryland	d 2 sh h and 7 is n traun		19a. Informant's Nar Mildred V.			J		Box 122,			2153		o code)
-	1 and Heelt Heelt		20a. Method of Dispo		MITE	20b. Pla		sition (Name of matory or other place				on - City or To	own, State
OL	ages ant of nt: If it			Cremation 3 5	Removal from State	9		lle Cemet	1	3. 2006	Gran	tsvil	le, MD
Baltimore,	permit. P Departme Importar any njur		21. Signa ure of Fun	ral Service Licen	see		22	2. Name and Addres	ss of Facility Ne	wman Fun	eral	Homes	, P.A.
<u></u>	<b>₹</b> □ = <b>3</b>		200		euna			P.O. Box				21536	Approximate
	Physician /Medical		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	Final	. Mete	istat	-ic		) CAN				Interval Between Onset and Death
Į	Examiner			ditions.	b. Obst	s a consequence of the consequen	ini	Jaun	dice				IMONTH
	uted d anslt	Examiner	Sequentially list con if any, leading to impresses. Enter Under Cause (Disease or in that initiated events		a ATRI	s a conseque		RILLA	AT 10 N	J			54RS.
68760,	icate be executed physicien and s the burial-transit	cal Exa	resulting in death) L	ast		s a conseque	ence of):	tery	Disea	SC			5YRS.
_		ledical											
P.O. Box	The law requires thet the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE:  23b. Was decedent in the past 12 r  1 □ Yes 2 ☑  9 □ Unknown	months?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,			Date of deliv Month	rery Day Year
	uires thet l signed by Id be deta	þ	Part II. Other signification	( . N	ontributing to death		Ifing in the u		en in Part I.	23e. Did tob	-4		the cause of death?
00	w require s been si should b	Completed	CHRAN	nc le	chal S	Insu	Hici	ency		24a. Was ar		b. Were auf	opsy findings available
æ	The lav te has age 2	E				- 1 - 300	J			autopsy perform	ned?	death?	ompletion of cause of
ital		Bec	25. Was case referr	ed to medical			-0		26. Place of Deal	th (Check only one	-		
>	Physician: The inthis certificate har all director, page	ToE	examiner? 1 ☐ Yes 2001	No	Hospital: 1 ☐ Inpat	fient 2 □ E	ER/Outpatie		4 Sunursing Inc	ome 5 Reside	nce 6 🗆	Other (Speci	fy)
o uo	E je e		27. Manner of Death 1 Annual 2 □ Accident	t 5 ☐ Pending investigation	28a. Date of In (Month, D		28b. Time o Injury	Wor	yat k? Yes 2 □No	28d. Describe ho	w injury oc	curred	
Division of Vital Records,	or Attending Physician: effer death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 4 Homicide	6 Could not b determined	289. Place of I	njury - Af hor etc. (Specify,		reet, factory, office		28f. Location (Str City or Town		ımber or Rur	al Route Number,
	To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical Co	25a. Conflier (Check only one)	Contifying Pt 2 Medical Exam	rysician: To the bea miner: On the basis and manner:	of examinati	viedge, deal ion and/or in	in occurred at the tile evestigation, in my o	the data and plans pinion, death occur	and due to the na red at the time, da	usa(s) and ate and place	mannar as ce, and due	stated to the cause(s)
	Fo the	Me	29b. Signature and	title of certifier	1	Α		29c. Licens	e number	29	9d. Date sig	gned (Month	. Day, Year)
	C>F0		Nah.	ahat.	Vanna	ا رط	UD.	D	58655		101	2/20	50 h.
	104VA		30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Type		- 0 0 0 0				- 0
	w ·		Sabahat 1	Nawab, M.	D., 32 Co			., Grants	ville, MD	21536			
-	Sta Regist	ate rar	31. Date filed (Mont	th, Day, Year)	2006 32. Regis	strar's Signat	ure	Anna St. 8					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	,	Certific	cate of	Death		F	Reg No. 2 (	106 2260
Physiciar		Decedent's Name (First, Midd	ile,Last)					2. Date of Dea	Day Yea	Time of Déath D
Medical Examin	er	Harold Dea		.s					er 28, 2006	0800 nrs
		4a. Facility Name (if not instituted 1118 Painter School I				b. City, Town, or L Swarton	ocation of D		4c. County of Garrett	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hours	4Hrs. 8. Date of B	irth (MM/DD/YYYY	9 Birthplace (State or Foreign
Director		214-62 <b>-</b> 9272	1XM 2F	5	4 Yrs.	WOTTE Days	Tiodis	March	/6/1952	Country) WV
>.		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Tow	n or Locati	on.				10d. Inside City Limits
ow any						511				1 Yes 2 X No
Maryland 28a-f show d at once.	핡	MD G	arrett	5W&	nton	10f. Zip Code			10g. Citizen of Wh	nat Country?
ne Mai or 28	ē	1118 Painter S	chool Rd			215	61		USA	
with the 18 23a see noti		11. Marital Status	12. Was Decedent E	ver in U.S.		Decedent of Hisp	anic Origin?	? (Specify Yes or N	o- 14. Race	- American Indian, 8lack,
death r iten	Funeral	1 Never Married 2 X N	1 Yes 2	X No		es, specify Cuban,		uerto Rican, etc.)	White	
after "al", o	<u></u>		ivorced If Yes, Give Year or Dates:			Yes 2 X No		d = 6 = d = d = -	Specify:	White
hours natur Exam	<u>8</u>	15. Decedent's Education (Spe Elementary/Secondary (0-12)				t's Usual Occupationst of working life.			16b. Kind of Bu	siness/industry
36 oin 72 than 'dical	Completed	12th	) Jonege (1 4 di 3		Labor	er			Car	pet Co.
ed with	탉	17. Father's Name (First, Middle	e, Last)				8.Mother's N	Name (First, Middle		<u> </u>
215 be file ntal H rked o	<u>&amp;</u>	Theodore -	Hebb				Juan:			Burns
D 21 hould nd Me is ma attic ev	-	19a. Informant's Name/Relation				,				n, State, Zip Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene  taut: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the <u>Medical Examiner</u> must be notified at once.	- 1	Tony Hebb/ Son  20a Method of Disposition				tion (Name of cerr		k Rd., Sw Date	20c. Location -	D 21550 City or Town, State
Ore, ges la of He of He ther t		1 X Burial 2 Crematic	on 3 Removal from Stat	te crem	atory or oth	ner place)		0.10.106	1, 1,	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 Donation 5 Other S		Fan		Cemetery ame and Address		.0/2/06 Stewart	Hendria	
Bal perm Depa Impo	-	B. OCAN	A					St., Oakl		
Physician	$\dashv$	23a Part I. Enter the disease, of failure. List only one caus-	or complications that caused t	he death. Do	not enter th					
/Medical Examiner	1	Immediate Cause (Final diseas	Treemodel in	toxicati	ion					Death
Zaillilei	-	or condition resulting in death)	Due to (or as a conse	quence of):						
Marine and the second	ᡖ	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):						
	튑	cause. Enter Underlying Cause	C			-				
ted Insit	Examiner	events resulting in death) Last	Due to (or as a consect	quence of):						
760, Icate be executed physician and the burial - transit	/Medical	X UNPENDED	¬	Ra 27 28	a-f nei	ME,g860, 1	0/25/00	5 TT		
ficate be g physic the burn	Med	IF FEMALE:	23c. If yes, outcom	e of pregnan	су				23d Date of	
687 certific		23b. Was decedent pregnant in past 12 months?	Live biltin	time of death			Ectopic pi	regnancy	Month	Day Year
Box 68 re death certiff the attending red for use as	Physicia	1 Yes 2 No 9 U	nknown 9 Unknown		5 Ot	her (Specify)				
ords, P.O. Box 68" w requires that the death certification is been signed by the attending should be detached for use as		Part II. Other significant cond	litions contributing to death	but not resul	ting in the t	anderlying cause g	iven in Part			ibute to the cause of death?
rres th	ē S						_	1Y		Probably 4 🗹 Unknown
ords v requ s been should	let e								opsy	Were autopsy findings available prior to completion of cause of
Recc The lav cate har	Completed							per 1 <b>✓</b> Yes		death? ✓ Yes 2 No
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deac	Be C	25. Was case referred to medic examiner?	I I A-1				Othor:	heck only one)		
vision of Vital For Arrange Physician: Rer death Director: After this certifier by the funeral director.	2	1 ✓ Yes 2 No	Hospital: 1 Inpatier		/Outpatient	0 000	Other <sub>4</sub> N	Nursing Home 5	Residence 6 e	
n of ding Pt After funeral		27. Manner of Death  1 Natural 5 Pe	28a, Date of Injur (Month, Day,Ye	ear)		1	ryat Work?			ieu
ivision or Atten after death Director:	cati	2 Accident Inv	vestigation Find 9/28		nd 7:3	et, factory, office b	_	28f. Location	(Street and Numb	per or Rural Route Number, City
Divipital or ours after the filled in	Certification:		ould not be	sidence				or Town Swanton	State) 1118 F	Painter School Road
Hospi 24 hou Funer cely fil		29a Certifier 1 Certifying	Physician: To the best of my	v knowledge.	death occu	rred at the time, da	ate and place	e, and due to the ca	use(s) and manne	er as started
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Ex	xaminer: On the basis of exar and manner stated	mination and/	or investiga			irred at the time, da		
F 3 F 3	ž	29b Signature and title of certi	ifier			29c Licens				ned (Month, Day, Year)
		Thurden.	U. K. 78		uis,	O.C.I	VI.⊏.		Septembe	7 29, 2000
		30. Name and address of person Theodore M. King, J	on who completed cause of d Ir., MD. Assistant M			111 Penn Str	reet Balti	impre, MD 212	01	
	a to			r's Signature		, , , , , , , , , , , , , , , , , , , ,	Joi, Daili		- 1	
Regist	ate rar	31. Date filed (Month, Day, Yea	2006	1	A	of .			_	
DHMH 17 Rev 1/20			A CONTRACTOR OF THE PARTY OF TH	res San	DRIGINA	L .				

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / I		artment of H				iene 20 (	) 6	32694
	Physici	an.	1. Decedent's Name (First, Middle,	, Last)					-	. Date of Deat Month	Day	Year	3. Time of Death
- 100 - 100	/Medic	_	Frances	Т.		laut	Z 4b. City, Town, or	Logation		Septemb	er 28,		11:25P. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, Kline Hospice				Freder		JI Death		Frede		
. 18	Funeral			6. Sex 7. Ag	ge (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8 Min.	. Date of Birth (Month, Day,			lace (State or Foreign
8	Director		142-10-6363	1□M 2⊠F	89	Yrs.	Month's Days	nouis	J	Tuly 28	, 1917		sylvania
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	ocation					1	0d. Inside City Limits
	Mary	tor	Maryland Free	derick	Fr	ede	rick						1 ☐ Yes 2XXNo
	or 28s	Jirec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V	Vhat Cour	itry?
	ath w	rail	6403 Oakley Te		Fire in II C	10	2170		igin? /Coop	fu Voc or No	USA 14 Bac	e - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural, or itama 23a or 28a-f show amy injury or other traumatic event, the Medical Exatural matter conflict at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes	n, Mexicar Specify:	n, Puerto Ri	can, etc.)		k, White,	
21215-0036	72 hou	ted	15. Decedent	's Education	16a	. Dece	dent's Usual Occupa	ation during mos	t of working	,	16b. Kind of Bu	usiness/In	dustry
21	ithin 7.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	)			0	**	
22	illed w Hygier ther th		12 17. Father's Name (First, Middle, L	Last)			Homemake		er's Name (	First, Middle,	Own Maiden Suman	Hom	e
and	id be id be ked o	To Be	77		nompson			Fı	rances	3	Eva	ıns	
Maryland	and M	-	19a. Informant's Name/Relationsh	nip (Type, Print)	19	b. Maili	ng Address (Street a	and Numbe	er or Rural I	Route Number	City or Town,	State, Zip	Code)
Z,	and and marking markin		Susan Mautz/Dau	ghter			Oakley Te	rrrac	ce, Fr		k, MD 2 20c. Location -		State own
NO.	iges 1 nt of H if ite or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		cemete	ary, cre	matory or other plac ash. Cem.	e)	10/03		Paramus		, State
Baltimore,	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signatore of Funeral Service I		Georg		2. Name and Addres	s ol Facili			Funeral		
Ba	Depa Impo any i		* Roserly 10	Xbr		1	621 Oposs	umtow					
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each St1	od the death. Do line. coke (Ce	not en	ter the mode of dyin rovascula	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
20.	/Medical Examiner		resulting in death)	Due to (or as	s a consequence	of):							
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	в а воперсенсе в в	rof):							
,092	ate be executed hysicien and he burial-transit	cal Exar	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	of):							
89	rtificat ng phy as th	edi	IF FEMALE:								1		
.O. Box	it the death certificat by the attending phy tached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □XNo 9 □ Unknown		e of pregnancy 2 Petal deat at time of death		□Ectopic pregnancy □ Other (specify)					te ol delive onth	ery Day Year
Ω.	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant condition  Bradycardia	ons contributing to death				en in Part I	l.				ne cause of death?
Vital Records,		Completed								24a. Was a autop: perfor 1 ☐ Yes	med?	prior to co death?	ppsy findings available mpletion of cause of
Vita	Physician: This certificated and director, p	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth			(Check only or			77
of	Phys r this ral dir		1 ☐ Yes 2 ☒ No 27. Manner of Death	1 [] Inpat	ient 2□ER/C jury 28b.	utpatie Time (	nt 3 DOA	4 🗆 N			ence 6x00th ow injury occur		y) Hospice
ion	nding lath th r: After e funer	ation	1 Accident 5 Pendin	9	ay Year)	Injury		k? Yes 2⊡	]No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place of Ir	njury - At home, etc. <i>(Specify)</i>	farm, s	treet, lactory, office		28	II. Location (S City or Tow		er or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edicai	one)	ng Physician: To the bes Examiner: On the basis and manners	t of my knowledge of examination a stated.	ge, dea ind/or i			nd place, ar ath occurred				
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	W			29c. Licens DO	e number 06235	52		29d. Date signe Sept 2		
	13		30. Name and address of person Dr. Aimee Par	k 180 Tho	mas Johr	ison	Dr. # 20	2 F1	rederi	lck, MD	21702		
e	St Regist	ate	31. Date liled (Month, Day, Year)	3 2006 32. R	trar's Signature	* /	Sporte						

Howard Daniel Mumma, Sr

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	0	0	6	3	2	6	9	5

		1- For State Certificate of Death Reg. No.													
Physicia		1. Decedent's Name (First, Middl	e,Last)							2	Date of D		V	Т	Time of Death
al Examir		Howard Daniel	MUMMA Sr								Month Septem	ber 2	ay 8, 2006		0051 hrs
	н	4a. Facility Name (if not institutio				41	o. City, Tov	n, or Lo	ocation o				4c. County o	f Death	
		17000 Block of Garlar				1	Hagers	town					Washing	ton	
Function	4	5. Social Security Number	6. Sex	7. Age (In	yrs. last bii	rthday)	If Under	Year	If Under	r 24Hrs.	8. Date of	Birth(N	/M/DD/YYYY)	9. Birti	nplace (State or
Funeral Director	- 1	218-50-2965					Months	Days	Hours	Min.	Ton	12	,1950	Foreigi	ntry)Maryland
Director	L	210-30-2903	1 X M 2 F		56	Yrs.					Jan.	14	,1900	- 000	- Tally Land
2	ŀ	Usual Residence of Decedent		1100	. City, Towr	or Locatio									10d Inside City Limits
w any	- 1	10a. State 10b. County		100											1 X Yes 2 No
and sho	5	Maryland Wash	ington		Hage	erstov									
faryl.	Director	10e. Street and Number					10f. Zip C					10g	Citizen of Wh		try?
th the Maryland 23a or 28a-f show notified at once.	히	350 Woodpoint	Avenue					217	40				US	SA	
with is 23 e no	ᅙ	11. Marital Status	12. Was De		r in U.S.						cify Yes or	No-			can Indian, Black,
eath iten	Funeral	1 Never Married 2 X M	arried Armed F	orces?	No	If Ye	s, specify (	Juban, I	Mexican,	Puerto R	ican, etc.)		White		
ter d		3 Widowed 4 Div	orced If Yes, Give Ye			1	Yes 2 🗙	No	specify.				Specify:	wh:	rte
urs af fural	<u>\$</u>	15. Decedent's Education (Spe	cify only highest gra	ide complet	ted) 16a	. Decedent						16	b. Kind of Bu	siness/Ir	ndustry
2 hoi "na	홢	Elementary/Secondary (0-12)	College (	1-4 or 5+)		during mo		ig life L	DO NOT	use retire	a)				
5-0036 led within 72 Hygiene. other than the Medical	mpleted	12	1			clei	ck					Į	J.S. Po	st	Office
d with	5	17. Father's Name (First, Middle	, Last)					18	3.Mother	s Name (	First, Middl	le, Mai	den Surname)		
11215-0036 d be filed within 72 hours after fental Hygiene. aarked other than "natural": event, the Medical Examines	Be	Galen Lynwood	Mumma						Ka	ay Ca	ther	ine	Smith		
21215-0036 uld be filed within 7 Mental Hygiene. narked other than c event, the Medica	일	19a Informant's Name/Relations			19	9b. Mailing	Address	(Street	and Num	ber or Ru	ral Route I	Numbe	r, City or Towr	n, State,	Zip Code)
MD d 2 shouth and in 27 is aumafic	$\vdash$	Darlene V. Mum	ma - wife	2		350 V	Voodp	oint	: Ave	e., H	lagers	sto	vn, Mar	cy1a	nd 21740
		20a. Method of Disposition				of Disposit		of ceme	etery,		Date	2	0c Location -	City or	Town, State
Baltimore, permit Pages I an Department of Hee Important: If iten	ı	1 X Burial 2 Cremation	n 3 Removal t	from State		atory or oth		rio	1	10_3	-06	I,	Jacoret	Own	, Maryland
imore Pages   ment of F tant: If i	Į	4 Donation 5 Other S			Cedar										
Baltimo permit Page Department Important: injury or ot		21. Signature of Funeral Service	Licensee				ame and A			1,1			FUNERAL		
<b>™</b> %∆5.€		James L.				415	E. 1	Vils	on E	Blvd.	, Hag	gers	stown,	Md.	
hysician		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the	death Dor	not enter th	e mode of	ayıng, s	uch as ca	ardiac or i	respiratory	arrest,	snock, or nea	art	Approximate Interval 8etween Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Contact G	unshot V	Vound of	f Head									Death
LAdillile		or condition resulting in death)	Due to (or as	a conseque	ence of):	-									
		Sequentially list conditions,	b												
	ne.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a conseque	ence of):										
	Examin	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):										
cecuted 1 and - transit	Ä	events resulting in death) Last	d	,	,										
760, icate be executed physician and the burial - trans	ledical	UNPENDED	AMENDED												
O, e be e ysicia buria	edi	Land .	702-2-2						_			-	23d. Date of	deliven	
3760, ficate be g physic s the bur	$\leq$	IF FEMALE: 23b. Was decedent pregnant in t			of pregnanc		al death	3	Ectopic	pregnan	cy		Month		ay Year
Box 68 e death certi the attending ed for use as	Physiciar	past 12 months?		gnant at tim			ner (Specii				•				
30) death	ysi	1 Yes 2 No 9 Ur	iknown 9 Unk	nown											
ords, P.O. Box 68' v requires that the death certifi s been signed by the attending should be detached for use as		Part II. Other significant condi	tions contributing	to death bu	ut not result	ing in the u	nderlying o	ause gr	ven in Pa	art I.	23e D	id toba	cco use contri	bute to	the cause of death?
P.O.	Ş										1	Yes	2 🗸 No 3	Prot	ably 4 Unknown
ds, equire	Completed	M. The state of th					-				24a W				topsy findings available
COFC law re has be	ble						_					utopsy erforme		rior to c death?	ompletion of cause of
Rec The I	Ö										1 🗸 Y	es 2	No 1	<b>✓</b> Ye	s 2 No
Vital Reo ysician: The his certificate director, page	Be	25. Was case referred to medica					26			(Check or	nly one)				
Vita hysici this c	.0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/	Outpatient	3 DC	A	Other <sub>4</sub>	Nursing	Home 5	Re	sidence 6 🕟	Other	: Scene
ision of Attending Ph. r death. rector: After the	Ξ.	27. Manner of Death	28a. Dat	te of Injury th, Day,Year)		o. Time of Ir	njury 28	c, Injury	y at Work		28d. Descr Subject s		v injury occurr	ed	
on ath. rr: A	ţį		iding	D: 2006	1	OUND: 20 hrs		1 Y	es 2 🗸	No	oubject s	SHOL S	oc II		
iSi Atte er de recte	ica				/ - At home,		t, factory,	office bu	uilding, et	tc :				er or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Certification:			y) Parkii	na Lot					1	7000 BI	n, Stat	e) of Garland	Groh	Boulevard, Hagers
lospital I hours uneral		29a. Certifier 1 Cortifuing F	Physician: To the b			death occur	red at the t	ime dat	te and pla	ace, and o	due to the	cause(s	s) and manner	as star	ted.
the Hos iin 24 h the Fur pletely	Medical	(Check only one) 2 Medical Ex	aminer: On the basi	s of examin	ation and/o	r investigat	ion, in my	pinion,	death oc	curred at	the time, o	date an	d place, and c	lue to th	e cause(s)
To the within 2 To the complete	Nec	29b. Signatore and title of certif	and manner	stated.					number						nth, Day, Year)
	_	250. 01910.00	0 1/0	001	) 1			O.C.N					September		
		ara	CHO		ul			J. O.10							
		30. Name and address of perso								0.100					
H-10+1			ssistant Medica	ıı Examir	ner 11	1 Penn S	street, B	altimo	ore, MD	21201					
S	tate	31. Date filed (Months Dev, Year	2 2006 32.	Registrar's	Signature	1	1 11 1								
Regis	trar			MARILLA	w N	100	was								
DHMH 17 Rev 1/2	2001				O	RIGINA	L								

06-07561 Wayne R Miller

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

R			rtificate of Death		a. No. 200	5 3269
Physici Medical Exam				2. Date of Death		3. Time of Death
A L	IIICI	Wayne R. Miller  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 7,		0420 hrs
		Prince George's Hospital Center	Cheverly		4c. County of Death Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		8. Date of Birth	(MM/DD/YYYY) 9. Bir	hplace (State or
Director	l.	577-74-1122 1XM 2F	52 Yrs. Months Days Hours Min.	08/29/	Foreig	n Wash., DC
ı,		Usual Residence of Decedent  10a. State 10b. County 10c. City.				
d now any		DC ITOS. COUNTY	Town or Location			10d. Inside City Limits
Maryland <b>28a-f</b> show 1 at once.	ctor	10e. Street and Number	Washing		g. Citizen of What Cour	1 XYes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	2202 81-4 0- 275 1		100	g. Citizeri di vvnat Cour	ury?
215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	eral	3393 Blaine St. NE - 1 11. Marital Status 12. Was Decedent Ever in U.		ecify Yes or No-	United 14. Race - Ameri	
r death or ite	Funeral	Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
s after	Ş	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:		The second second second	Black
5-0036 Iled within 72 hours Hygiene other than "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir	ork done ed)	16b. Kind of Business/li	ndustry
036 ithin 7 ne r than ledica	nple	12th	D41.1 - 1	i		
5-0 lled w Hygie I other		17. Father's Name (First, Middle, Last)	Disabled 18.Mother's Name	(First, Middle, Ma	Nor	<u>e</u>
2121: Jid be fil Mental I marked event,	o Be	Henry Powell		Heler	L. Miller	
1D 21215-003 2 should be filed within and Mental Hygiene 27 is marked other th matic event, the Medi	ĭ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or R	ural Route Numb	er, City or Town, State,	Zip Code)
imore, MD 2 Pages I and 2 shou ment of Health and I iant: If item 27 is n or other traumatic		Freida Hancock/Sister  20a. Method of Disposition 20b. F	3800 Forest Grove D		andale, VA 20c. Location - City or	22003
nor ages l int of l ut: If		1 X Burial 2 Cremation 3 Removal from State	crematory or other place)			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygene Important: If item 27 is marked other than injury or other traumatic event, the Medica		4 Donation 5 Other Specify: Har: 21. Signature of Funeral Service Licensee	mony Memorial Park 10/			
Der De		John T. Stewart III	4001 Ronning DJ	MIT T	neral Home	
Physician /Medical		23a. Party. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death)				Between Onset and Death
		- Due to (of as a consequence of	·):			
	ner	Sequentially list conditions, if any, leading to immediate use. Enter Underlying Cause	):	<del></del>		
	aminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	):			
760, icate be executed physician and the burial - transit	EX	d				
760, icate be executed physician and the burial - transi	edical	X UNPENDED #23a.27.De	erME, G862, 12/8/06 TT			
3760, ificate be g physicist the buri	Σ	IF FEMALE: 23b. Was decedent pregnant in the	nancy		23d. Date of delivery	
Box 687 death certifu he attending for use as t	icial	past 12 months? 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregnan  3 Other (Specify)	су	Month Da	y Year
0 20	Physician	1 Yes 2 No 9 Unknown 9 Unknown				
, P.O. res that the signed by be detach	by F	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I		cco use contribute to the	
ds, I					2 No 3 Proba	
COF	Completed			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
tal Recision: The certificate		25 Was approximately and the		1 <b>Y</b> Yes 2	ed? death? No 1 ✓ Yes	2 No
/ital	Be	25. Was case referred to medical examiner?  1 Vas 2 No. Hospital: 1 Inpatient 2 V	26.Place of Death (Check or ER/Outpatient 3 DOA Other Nursing			
ing Phy ing Phy After th	<u>ان</u>	27. Manner of Death 28a. Date of Injury		Home 5 Re	sidence 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  In Director: After this certificate has been sted in by the funeral director, page 2 should I	tio	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No		,,	
ivisior  or Attencather death  Director: d in by the	ific		me, farm, street, factory, office building, etc. 2	8f. Location (Stre	eet and Number or Rura	I Route Number, City
Division of Vital Records, P.O. I Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the tell yilled in by the funeral director, page 2 should be detached.	Certification:	4 Homicide determined (Specify)		or Town, State		i)
	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and manager stated.	e, death occurred at the time, date and place, and d	ue to the cause(s	) and manner as started	1
To the within 7 to the Complet	Med	and manner stated  29b. Signature and title of certifier	29c. License number			
		() 11/	O.C.M.E.	1.	9d. Date signed (Monti October 8, 2006	n, ∪ay, Year)
	}	30. Name and address of person who completed cause of death (Item 2				
CK		Jack Titus MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, MD 212	01		
	_	31. Date filed (Month, Day, Year)  OCT 1 2 2086  Registrar's Signature	land.		<del></del>	
Regist		OCT 1 2 2086 Steen &	you			

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Ma	arylan	d / Dep <i>Ce</i>	artment c rtificate	of Hea of De	lth and N <i>ath</i>	Mental Hy	ygien Reg. N	_	32697
			Decedent's Name (First, Middle, La	st)						2. Date of D	eath		3. Time of Death
	Physicia /Medic		Margaret Marie M				T ==		V 1277	Octobe	er O	4, 2006	02:40 AM
	Examin Funeral Director	er	4a. Facility Name (If not institution, giv 16771 Taylor's La 5. Social Security Number 6. S 232-26-6438	nding Road	e (In yrs. I	last birthday 86 Yrs.	Shar	osbur	Jnder 24 Hrs.	8. Date of B (Month, D May 12	irth Day, Year	C. County of Death  Washing to the state of	DON place (State or Foreign
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or L	ocation						10d. Inside City Limits
	shov	2	MD Washing	ton		cock	ocation						1 ☐ Yes 2 ☑ No
	28a-f	rect	10e. Street and Number	COII	Пап	COCK	10f. Zip Co	de			10a. C	itizen of What Cou	
	3a or	Ö	4763 Casper Roa	d			21	750			11	SA	
•	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "naturat", or Items 23a or 28a-f show marked other than "naturat", or Items 23a or 28a-f show maric event, the Madical Exertiner resultse nutilised at	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		S. 13.	Was Decedent If Yes, specify	of Hispar Cuban, M		ecify Yes or N Rican, etc.)		14. Race - Ameri Black, White,	
21215-0036	rat', o	ρ	3√7 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□ Yes 2X	No Sp	pecify:			Specify:	White
5	72 ho	Completed by	15. Decedent's E (Specify only highest gra			16a. Dece (Giv	edent's Usual O be kind of work d DO NOT use re	ccupation	g most of work	ring	16b.	Kind of Business/Ir	ndustry
2	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5	i+)		Mill O				Wo	od Mill	
0 0	filed Hygid Sthar ent, II	ပိ	17. Father's Name (First, Middle, Last,			wood	HLLL O		Mother's Nam	e (First, Middl			
<u>la</u>	ould be Mental arked o	To Be	Norman C. Roach					El	ldora B	ohrer			
Maryland	and Name		19a. Informant's Name/Relationship (	Туре, Print)	•						-	or Town, State, Zij	
	and 2 ealth m 27 I		Donald Miller/Son		001 0	1677	L Taylor	c's I	anding	Road S	Shar	psburg, MI Location - City or T	21782
altimore,	ges 1 if of H if ital		20e. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		a	өтөгөгү, ст	matory or other	place)	i				
Ē	it. Pa rtmen rtant: njury		'4 □ Donation 5 □ Other (Special Signature of Funeral Service Licenses)		Gre		Cemete: 2. Name and A					keley Spr	
Ba	permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 Is marked any injury or other traumatic es		21 Signature of Furieral Service Like	SA	- 2 20				Т			in Street	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	n. Do not er	ter the mode of	dying, su	ich as cardiac	or respiratory	arrest,	ck,MD 217	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ocar	cinon	ia of T	he L	ung				Onset and Death
	Examiner		Sequentially list conditions,	b									
	ad sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):							
58760,	e be e siciar e buria		(	d								4	
_	tificate ig phy as the	ledicai											
P.O. Box	Attanding Physician: The law requires that the death certif rideath. actor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be delached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	□Ectopic pregn □ Other (specif					23d. Date of deliv Month	ery Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	contributing to death b	ut not resi	ulting in the	underlying caus	e giv <i>e</i> n in	Part I.		tobacco	/	the cause of death? bably 4 Dunknown
Division of Vital Records,	The law re ate has bee	Completed								24a. Wa auto per 1 Yes	opsy formed?	prior to co	opsy findings available ompletion of cause of
ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?						Place of Deat				
<u>5</u>	Physic this or al dire	ို	1 ☐ Yes 2 ☐ No				nt 3 DOA		□ Nursing Ho				WHame of San
UC.	ding F h. After funer	ion:	27. Manner of Death  1 Natural 5 □ Pending  2 □ Accident investigatio	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury	M 28C.	Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe	a now inj	ury occurred	
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 200 Place of Ini						28f. Location City or To	(Street a	and Number or Rur te)	al Route Number,
_	e Hospita 24 hours a Funaral	Medical C		nysicien: To the best niner: On the basis o and manner st	f examina								
	To th within To th compl	Me	29b. Signature and title of certifier	111			_	cense nur			_	ate signed (Month,	*
			> Watthen	Halm M	<i>I</i> )		Di	5604	8		()e	tober 5, 2	006
	13		30. Name and address of person who Mullhew-Hahn	completed cause of a	eath (Item	123a) (Type	Print) Hanco	ck,	Maryl	and 2	1750	0	
	Sta Registr		31. Date filed (Month, Day, Year)	006 32. Registo	an's Signa	ture	hostes		1				

State of Maryland / Department of Health and Mental Hygien [2] 1 6 32698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death < Month Day Year **Physician** Deplember 25 1050AM Theodis Nelson 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital Prince George's Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 91 Director 256-09-7683 Dec. 24, 1914 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1X Yes 2 □ No Director Maryland Prince George's Riverdale 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6620 Auburn Ave. 20737 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 K Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married aryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 12 should be filed within h and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8th Building Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John H. Nelson Mary Harris ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 si if Health ar 5055 E. Capitol St., SE Wash., DC 20019
Date 20c. Location - City or Town James Cole/Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H.
Important: If ites
any injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 10/2/2006 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature a Funeral Service Licensee Stewar 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 8Vh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Corunary Physician athero selevatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Year Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ➤ No 24a. Was an page 2 autopsy performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director; After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 55697 MO 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 575 Main Street, Suite 351, Laurel, MD. 20707 uan-Anh T. Vu 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 7 2006 Registrar

06-07532

#### Please Type or Print in Black Indelible Ink

Rosa Nunez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 6, 2006 Dolores Nunez Rosa 0917 hrs Medical Examiner 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State of English Date) 5 Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Directo 090-60-6179 Country) Republic 1 M 2 XT Tan. 26, 1925 Usual Residence of Decedent 10a State 10c City, Town or Location 10d Inside City Limits 'n Yes 2 X No 28a-f show Takoma Park Maryland hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7600 Maple Avenue, #1704 20912 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes 9 1 X Yes 2 No specify Dominican Specify. White If Yes Give Year Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Hygiene d other than " the Medical I filed within 72 MD 21215-0036 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filed ment of Health and Mental Hytant: If item 27 is marked or event, Be Alejandro Tatis Martina Taveras 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Felix A. Nunez/ Husband 7600 Maple Avenue, #1704, Takoma Park, MD 20912 nt of Health a nt: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Oct. 11, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 2006 Silver Spring, Maryland Department or Important: injury or oth Donation 5 Other Specify. 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee Ken Skille MD 2090 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death End stage renal disease with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) d and Physician/Medical X UNPENDED **AMENDED** attending physician for use as the burial #23a,27,perM.E g863 1/19/07 TT Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> Hospital: 1 / Inpatient Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No Director: after death Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be determined t 24 hours a Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 7, 2006 Mul 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (M 32. Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State of	f Maryland		artment of F		ınd Men		ene 2 0	06	32	700
	Physici		Decedent's Name (First, Middle  DIDY  TO THE PROPERTY OF	,	NA GEL DOL				2. C	Date of Death Month Detember	Day 28	2006	3. Time o	
1	/Medio Examir		RUBY I  4a. Facility Name (If not institution		NAZELROI	<u> </u>	4b. City, Town, o	or Location of		Cenber	4c. Count		10.4.	
	CAMIIII	CI	FREDERICK MEMO				FREDERI				FREDE	200		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 2		Date of Birth Month, Day,			lace (State	or Foreign
	Director		579-48-6402	1□M 2 <b>X</b> F	75	Yrs.	WOITING Days	Tiours		ine 18,			st Vir	
	and and		Usual Residence of Decedent  10a. State 10b. County	,	10c. City,	Town or Lo	cation					1	Od. Inside C	ity ! imite
	Mary	jo	Maryland Fred	erick		Bruns	wick							2   No
	1 the	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of	What Cour	itry?	
	th with		524 West C. S	treet			2171	16			United	l Stai	tes	
	dea dea	Funeral	11. Marital Status	Armed For	edent Ever in U.S	3. 13.	Was Decedent of H		in? (Specify		14. Rad	ce - Americ	an Indian,	
9	s afte	by Fu	1 Never Married 2 Mar	nied 1 □ Yes If Yes, Giv	<b>2</b> X∏ No ⁄9		1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,	11, 010./		v: Whi		
9500-61212	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or items 23e or 28e-1 show event, the Medical Exerninal must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:		dent's Usual Occur							
Ċ	n ne	Completed	(Specify only highe	st grade completed)		(Give	kind of work done DO NOT use retire	during most ( d)	of working	10	6b. Kind of B	usiness/ind	ustry	
7	d with	mo	Elementary/Secondary (0-12)	College (1 +2	-40r5+)	Teac	her's Aio	le			F	Educat	ion	
	al Hygid I other	Bec	17. Father's Name (First, Middle,	Last)					's Name (Fin	st, Middle, Ma				
<u>8</u>		To	Julian B. Le	wis						1 Broo				
Maryland	d 2 should th and Mer 7 ie marke traumatic		19a. Informant's Name/Relations		la de la companya de		ng Address (Street						Code)	
<b>a</b>	1 and Health em 27 ther t		Ivan Nazelrod / 20a. Method of Disposition	nusbanu	20b Pla		West C.	Stree	Date	-	oc. Location		- Ctata	
Saltimor	pernit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		1  Burial 2 □ Cremation		State Cer	metery, crer	natory or other pla							
	artme ortan injury		4 ☐Donation 5 ☐ Other (S 21. Signature a Funeral Service		Brow	-	le Cem.  Name and Addre		0/2/20		rownsv			
ñ	Dep Imp		Youtne 1	Stault	lon		100 N. Ma							
	Division		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that ca	aused the death.	Do not ent	er the mode of dyir	ng, such as ca	ardiac or res	piratory arres			Approximation of the control of the	tween
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due tolk	or as a conseque	Mce of):	ailure	(Mr	(05)			-	Wer	te.
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a conseque	ence of):							- MARK	
	cate be executed physicien and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>										
Š	e exection and an arrigil-tr	Exa	resulting in death) Last	Due to (	or as a conseque	ence of):								
0/0	ate be hysici the bu	dical		d										
ŏ ×	death certificate be executed e attending physicien and ed for use as the burial-transit	Mec	IF FEMALE:	00- 4		11/1	4					- 1		
0	eath c attend for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	come of pregnand irth 2 □ Fetal o ant at time of dea	death 3□	Ectopic pregnancy	1				te of delive inth	•	Year
j	the de	iysic	1 □ Yes 2 ☑No 9 □ Unknown	9□ Unkno		in 5	Other (specify) _					1	)/A	
ŗ	s that		Part II. Other significant condition	ms contributing to de	ath but not result	ting in the ur	nderlying cause giv	en in Part I.	2	23e. Did toba	cco use cont	ribute to th	e cause of c	death?
Sorus,	quire; en sig uld be	Completed by	Group & Shep back	reing ,	an crent	it's	, Afrial	Fbull	stion	1 🗆 Yes	2 No	3 Proba	ably 4 🗆	Jnknown
ວ	awre	plet	Pulmonay emb	alism,	Astlame	4			2	24a. Was an	24b. '	Were autop	sy findings	available
č	The ate has page	E	0						_	autopsy performe □ Yes 2√	d2	death?	npletion of c 2□ No	A A
<u> </u>	cian: ertific actor,	Be (	25. Was case referred to medical examiner?					26. Place o		eck only one	11			-//\
5	Physi this c al dire	၉	1 Yes 2 No				t 3 DOA Oth	4 🗆 14012		5 Residence			)	
	ding h. After funer	E C	27. Manner of Death  1 ☑Natural 5 ☐ Pendin	9	h, Day Year)	8b. Time of Injury	28c. Injur Wor	yat k? Yes 2.⊟No	1	Describe how	injury occur	red		
2	deat deat ctor: y the	flca	2 Accident investig	not be	of Injury - At hom	ne. farm. str		165 2 10		ocation (Stree	N/A	er or Rural	Route Num	bor
5	s after s after self or s	Certification;	4 ☐ Homicide	buildin	ng, etc. (Specify)	JA	on, idealy, amou		- 0	City or Town, S	State) A	or or ribrar	710010 140///	Der,
	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours atten death:  within 24 hours atten death:  To the Funeriel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the Examiner: On the ba and mann	isis of examinatio	ledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and d	ue to the caus the time, date	se(s) and ma and place,	inner as sta and due to	ated. the cause(s	i)
	To the To the comp	Me	29b. Signature and title of certified	0			29c. Licens			29d	. Date signed			
			) (Ind	mesa				6456	8		9-28	5-06	9	
٧	0		30. Name and address of person VIVIAN OFCHO		of death (Item 2		Print) RUNSUM	k M	MO 41	716				
	Sta Registr		31. Date filed (Month, Day, Year)  OCT (	3 2006 32. R	rar's Signatu	TO ST.	book	1-1.4						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Helen Anne Norman 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 7, 2006 1219 hrs Medical Examiner Helen Norman Α. 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Beltsville Prince George's 10403 -A 46th Avenue 5. Social Security Number If Under 1 Year | If Under 24Hrs. | 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Dec.6,1957 48 Director 449-59-7239 1 M 2 X Liverpool, England Usual Residence of Decedent IOc. City, Town or Location 10d Inside City Limits any 10b. County Beltsville Yes 2 X No Maryland Prince George's 28a-f show Director 10e Street and Number 10f. Zip Code 20705 United States Citizen of What Country 10403A 46th Avenue, #107 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married Yes White 1 Yes 2 X No specify Specify Widowed 4 Divorced f Yes. Give Year à 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 12 5+ U.S. Government Biochemist should be filed within and Mental Hygiene 17. Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) Marjorie Hind Anthony John Norman Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) nt of Health and N it: If item 27 is n other tranmatic Stephen Francis Norman -brother 26 Yule Road Coventry CV23DB England, United Kingdom 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State permit Pages La
Department of Hi
Important: If it
injury or other t crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory9/25/2006 Alexandria, Virginia Donation 5 Other Specify Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland20705 on Approximate Interval Between Onset and Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical Death Immediate Cause (Final disease Atherosclerotic cardiovascular disease **⊆**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical XUNPENDED AMENDED item#23a,27,perME,g860, 10/17/06 TT Box 68760, IF FEMALE 23d Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 240 Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No. 1 V Yes 25 Was case referred to medical 26 Place of Death (Check only one Hospital or Attending Physician: Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 5 Pending 1 Yes 2 No Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the the and manner stated 0 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 8, 2006 mpleted cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State

Registrar

32, Registrar's Signature

6 2006

State of Maryland / Department of Health and Mental Hygiene, 32702 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 24 2006 5:35AM ANGIE LOURDEZ PEREZ OCHOA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner NATIONAL INSTITUTES OF MONTGOMERY HEALTH BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗗 F Days Yrs. 13 1992 Guatemala 14, Director none Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits r than "natural", or Items 23a or 28s-f ehow tre Medical Examinar must be notified at 1 X Yes 2 ☐ No Perona-Zona 8 Villa Nueve Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Avenida B 8-16 None Guatemala Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: Guatemala Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny language or other traumatic event 2008. Be Maria Ochoa Pablo Perez Ernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Avenida B 8 Perona-Zona 8 -16 Villa Nueve, Guatemala Maria Ochoa/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 10-3-2006 4 □ Donation 5 □ Other (Specify) Reforma Funeral Home Guatemala City, Guatemala 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LYMPHICYTIC Physician ACUTE YEAR /Medical Due to (or as a consequence of): Examiner IMMUNISUPPRESSION M. ~7H) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit INFECTION 1 MONTH Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 RESECTI. ~ Physician/Medical SMALL BOWEL IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 X No Yes 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060352 U. -MD PHD MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 SU YOUNG KIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 2 8 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Рм September 27, 2006 Gregory Α. Perrell /Medical 4a. Facility Name (If not institution, give street and number) 6917 Elbrook Road 4c. County of Death 4b. City. Town, or Location of Death Examiner Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex. 1[4]M 2□ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Vrs 218-02-3106 37 4/1/1969 Director Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ir than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1⊕ Yes 2 □ No MD Director Prince George's Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6917 Elbrook Road 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 57 No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounts Payable Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fit ment of Heelth and Mental H lant: If Item 27 is marked ot Be Joseph F. Perrell Catherine West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: If Item 27 is eny injury or other training. Catherine Perrell ( Mother ) 6917 Elbrook Rd. Lanham, MD 20706 20a. Method of Disposition

YE Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fort Lincoln Cemetery 10/2/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Road Brentwood, MD 20722 Tuherd romysto 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 months Sarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes **2/2** No Attending Physician; director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending iours after death. neral Director: Aft filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a
To the Funeral C the Hospitel 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dausa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title ef certifier D62878 9/29/2006 asuer. MIST 30. Name and address of person who completed wuse of death (Item 23a) (Type, Print) Nina Johnson-Wagner, M.D. 401 N. Broadway st. Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 9 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artmen <i>tificat</i>	t of He e of C	ealth a Death	and Me	ental Hyg	iene 0	06	32704	
#. ·	Physici /Medic		Decedent's Name (First, Middle, Last)     ALISA					2. Date of Deat Month SEP 26	Day	Year	3. Time of Death 12:41 A M				
	Examin		4a. Facility Name (If not institution, give s NATIONAL NAVAL ME		4b. City,	Town, or BETH	Location o	of Death		4c. County	OMERY				
	Funeral ' Director		5. Social Security Number 6. Sex Un-Avail:		. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	Haurs	Min. S	8. Date of Birth Month, Day, ept 25	<sup>Y</sup> °2006	Cou	place (State or Foreign ntry) 1land	
	Maryland n-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G	eorge's	Upper Marlboro				)			10d. Inside City Limits 1X Yes 2 □ No			
	with the	Director	10e. Street and Number 12806 Rhine Roa	d			10f. Zip	Code 207	72		1	0g. Citizen of US		ntry?	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  any injury or other traumatic avant, the Medical Examinar must be notified at 200ce.	by Funeral			lent Ever in U.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica  2 No Specify  1 Yes 2 No Specify					gin? (Spec , Puerto R	city Yes or No- lican, etc.)	14. Rac Bla	14. Race · American Indian, Black, White, etc.  Specify: Black		
	within 72 ho liene. r than "natur lie weerel	Completed	(Specify only highest grade completed) (Giv				lent's Usua kind of wor DO NOT us NOT	rk done du se retired)	iring most	of working		16b. Kind of B	None	ŕ	
land ;	uld be filed Mental Hyg irked other itic avant,	To Be C	17. Father's Name (First, Middle, Last)  Carlton Perry				18. Mother's Name (First, Middle, Maiden Sherice Reams						ne)		
Mary	ind 2 sho alth and h 27 ie ma ir trauma		19a. Informant's Name/Relationship (Ty) Carlton Perry (								Route Number Marlbo				
more,	Pages 1 a ent of He nt: if Itam ry or othe		20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from S	tate ce	ace of Dispo metery, crem sapeak	natory or o	ther place		Da /29/2		20c. Location - Belts			
Balti	permit. Departm importal any inju		21. Signatural Funeral Service License	onla		22	. Name an	d Address	of Facility	Rend	on/Hale	Funer	al Ho	ome	
	nysician		23a. Part1. Enter the disease, or compli- shock, or heart dilura. List only on Immediate Cause (Final disease or condition	_	used the death.		er the mod	e of dying	, such as	cardiac or	respiratory arre	est,	1	Approximate Interval Between Onset and Death	
	/Medical Examiner	resulting in death)  Due to (or as a consequence of):													
·	executed nend al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	r as a consequ r as a consequ											
68760,	icate be executed physicien end s the burial-transit	dlcal	C	-											
.O. Box (	The law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 [X] No 9 □ Unknown		Ectopic pregnancy Other (specify)					1	23d. Date of delivery Month Day Year				
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underly					erlying cause given in Part I.				oid tobacco use contribute to the cause of death?  ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown			
l Reco	The law re ate has bee page 2 sho	Completed									24a. Was a autops perform	y prior to completion of cause of			
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (Check only										
	Phys this aidi	atlon: To	1 Yes 2 XNo  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of	16 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho					28		5 Residence 6 Other (Specify)  Describe how injury occurred			
Divisi	i Dift o	Certification:	3 Suicide 6 Could not be determined	ne, farm, str						reet and Number or Rural Route Number. , State)					
	Hospital 24 hours a Funerai I stely filled	cal	29a. Certifier (Check only 2 Medical Examir	ician: To the b	est of my know	vledge, death	occurred	at the time	e, date and	d place, ar	nd due to the ca	tuse(s) and ma	anner as s	stated.	
	To the H within 24 To tha Fi complete	Medical	one)	and manne	or stated.	on and or th									
	S in S	2	29b. Signature and tyle of certifier	in 1	ND			1012	number 39328	3 (VA		SOPT.		200 6	
	4)		30. Name and oddress of person who co	mpleted cause	of death (Item		Print)				IAVAL ME ID 20889	DICAL			
	Sta Registr	100	31. Date filed (Month, Day, Year) SEP 2 9 2006		gistrar's Signati		R)								

Lois Price

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 23, 2006 Medical Examiner 1059 hrs Lois Kathryn Price 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Nov. 21, 1916 Country) PA. M 89 2 X F 579-32-1617 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d Inside City Limits 1 X Yes 2 No 23a or 28a-f show notified at once. MD. Anne Arundel Crofton death with the Maryland Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 906 Eastham Court #21 21114 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, 8lack Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 2 X No should be filed within 72 hours after and Mental Hygiene 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify White Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene ant. If item 27 is marked other than by other traumatic event, the Medical Homemaker Own home 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William H. Craft Clementine Davis ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Price-daughter in law 1688 Fallsway Drive, Crofton, Maryland 21114 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09-27-06 permit Page Department Important: injury or otl Crownsville, Maryland Marvland Veterans Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Prensee 22. Name and Address of Facilit Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ò نے 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Others After this 1 🗸 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' 28d Describe how injury occurred 1 🗸 Natural Division 1 Yes 2 No Director: d in by the f Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hours a determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 24, 2006 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 SEP 2 7 2006 32. Registrar's Sign Registrar

DHMH 17 Rev 1/2001 OCME 2006 1 - State Registra

POLLY PATRICK

Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 0 6

2. Date of Death

Day Month **Physician** PHYLLIS W. PATRICK SEPTEMBER 28 2006 1:50 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** TALBOT EASTON 208 BROOKLETTS AVE. 8. Date of Birth (Month, Day, Year) NOV. 2, 1926 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 K F Months 79 Yrs. Director 213-22-7652 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Mudical Examples in the figure must be inclined at 1 XYes 2 □ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 BROOKLETTS AVE. 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 XNO 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na: any injury or other traumatic evant, the Mudic ODEs. Elementary/Secondary (0-12) 11 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LLOYD W. WARNER DOROTHY SHUBKAGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. STANLEY PATRICK/SON 318 N. WASHINGTON ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) SPRING HILL CEMETERY 10/3/2006 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 Joseph · Kl C.F.SP. USTIZIUSKi 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cancer 3 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Orsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed the attending physicien and Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Nes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 Yes Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Pl 24 hours after death.
 Funeral Director: After the 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License numbe 9/29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 PINTAIL DR., DAVID SMITH M.D. EASTON, MD 21601 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 3 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 32707 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Catherine Ellen Poole October 2006 10:14a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Lutheran Village Hagerstown Washington 5. Social Security Number 219-05-0062 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept. Date of Birth Sept. Day 0 ear 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 F 88 Director Usual Residence of Decedent death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Marylann of Health and Mental Hygiene.
The file and Mental Hygiene "natural", or Hems 23a or 28a-f show then traumatic event. Ite Madical Extender must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington MD Hagerstown N Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status White etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry residence Homemaker Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Miles Mary Ward 19a. Informant's Name/Relationship (Type, Print) Cheryle A. McCarter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Woodpoint Ave. Hagerstown, MD 21740 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul Cemetery 2006 Oct.6, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 Burial 2 Cremation 3 Removal from State Clear Spring, MD permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Donald Edwin Thompson Funeral Home, Inc 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Athnose Immediate Cause (Final disease or condition resulting in death) Cardio-vascular **Physician** 2 mour /Medical Due to (or as a consequence of): Examiner Kedney 2 mail Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner aw requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been a 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 TYes Attending Physician: After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the functions. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D283 65 10-3-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street Hagristam ANZAN. 25 HAM SH-4 368 null 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 32708 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death sept. Physician 27° 20ď6 Bayani G. Romulo 8:11P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Jan. 25, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□ F Philippines 214-37-7855 Yrs Director Usual Residence of Decedent with the Maryland il Hygiene. other then "naturel", or Iteme 23e or 28e-f ehow vent, Itte Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Prince George Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6482 Bock Rd. #202 20745 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Filipino Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Legal Matters permit. Pages 1 and 2 should be filed w Dapartment of Health end Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, that once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Apolinario Romulo Felisa Garate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candida R. Romulo/Wife 6482 Bock Rd. #202 Oxon Hill, Md. 20745 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory or other place) 10/2/06 Edgewater, Maryland 21. Signature Funeral Service Licen: 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part / Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician De /Medical Due to Examiner - End Stage Renal Disea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be deteched 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 Yes 2 2 No To the Hoepital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and this to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of deal (Type, Print) ROSARIO OLD BRANCH AVE.CLO 2 PERNANDEZ 7700 31. Date filed (Month, Day, Year) State Registrar 9 2006

DHMH 17 Rev 1/2001

		í	1 - For State Registrar	State of Ma	aryland /	/ Depa	artment tificate	t of H	ealth a	and M	ental Hyg	iene	006	32709		
			Decedent's Name (First, Middle, La	ist)							2. Date of Death Month	h	Vana	3. Time of Death		
	Physicia /Medic		Dotsie Mae						Septembe	September 28,2006 11						
•	Examin		4a. Facility Name (If not institution, gir	re street and number)			4b. City,	Town, or	Location o	of Death		4c. County of Death				
			Prince George's 5. Social Security Number 6.	Hospital C	Center			heve		04)1				eorge's		
	Funeral				e (In yrs. last 36	birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 8/26/20	Year)	9. Birtl	hplece (State or Foreign untry) raw,S.C.		
	Director		579–26–3582 Usual Residence of Decedent	X C	,,,						0/20/2		CIIC	Lawy De Ce		
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation		-					10d. Inside City Limits		
death with the Maryland	e-f si	ctor	D.C.			Was	hingt	on						1 ☐ Yes 2 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygione. Importent: if item 27 is marked other than "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Madical Examiner must be notified at ODGs.	Funeral Director	10e. Street and Number 212 53rd St.,1	1.E.			10f. Zip	Code	2	20019	) 10		on of What Co U.S.A.	untry?		
	death	nere	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Nas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1.	4. Race - Ame			
0	or Ite	II.	1 ☐ Never Married 2 ☐ Married	1 Yes 2 1		1	rres, spec 1 □ Yes 2		Specify:	i, Puerto r	rican, etc.)		Black, White Specify: Af			
3	ureľ,	d by	3 ₩ Widowed 4 Divorced	Year or Dates:									Am	erican		
2	"net	Completed	15. Decedent's E (Specify only highest gr	ducation ade com <i>pleted)</i>	1	6a. Deced (Give	ient's Usua kind of wor DO NOT us	k done d	ition <i>uring</i> most	t of workir	ng	16b. Kin	d of Business/	Industry		
7	withir ene. then	щ	Elementary/Secondary (0-12)	College (1-4or 5	5+)		eauti					На	irdres	sing		
<b>7</b>	filed Hygid other ent, I	0	17. Father's Name (First, Middle, Las				00101			r's Name	(First, Middle, N					
yland	Mental Mental arked c	To B	James Evans								Robins					
Z	nd 2 sho eith and 27 is m ir treum		19a. Informant's Name/Relationship Patricia D. Lass:		ter	19b. Mailin 212	ng Address 53rd	St.,	nd Numbe N.E.	or or Rura Was	Houte Number, shington	,D.C	70wn, State. 2 2001	(ip Code)		
ē,	of Her item		20a. Method of Disposition	7-	20b. Place	e of Dispo	sition (Nam	ne of ther place	9)				ation - City or			
Ē	Page nent c nt: if ury or		1 Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci		Harr	nony	Mem.	Park		10/5/	/06	Lar	ndover,	Maryland		
Baltimo	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	risee Prair	,	22	H.S.W 1925 E	ashi Burro	ngtoi ngtoi	Å & S Ave.	Sons Co.	,Inc	ngton,	D.C.20019		
			23a. Part1. Enter the disease, or con	plications that caused	d the death. [									Approximate Interval Between		
Ph	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition FATAL CARDIAC ARRHYTHMIA													
	/Medical		resulting in death)	a. Due to (or as				.,,,,	1. 112							
	Examiner		Sequentially list conditions	b												
	D #	ner l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	es of):										
	be executed ician and burial-transit	Examiner	cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
oc,	be exician burial	calE		d =												
200	phys s the	_														
XO	w requires thet the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	3d. Date of deli	iverv		
Ď	death e atte d for	Ca	in the past 12 months?	1 □Live birth 4□Pregnant at			Ectopic pro Other (spe						Month	Day Year		
į	t the by the tache	hys	9 ☐ Unknown 9☐ Unknown													
, T	s the	by P									e contribute to	the cause of death?				
ğ	en sig										1 🗆 Ye	s 2 🗆	No 3 □ Pro	obably 4 Unknown		
Hecords	8 8 6	Completed									24a. Was ar autops perform	y ned?	prior to death?	topsy findings available completion of cause of		
	lan: rtifical tor, pi	0	25. Was case referred to medical				Me alte		26. Place	of Death	1 ☐ Yes 2	No No	1 Yes 2 No			
-	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatie	ent 2∭XER	/Outpatien	t 3 DO	A Othe			ne 5 🗆 Reside		Other (Spec	cify)		
0	ng Pth fter th neral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28	b. Time of Injury	2	8c. Injury Work	at	2	8d. Describe ho	w injury	occurred			
0	eath or: A	cat	2 ∐ /\ccident investigation				М	1 🗆 Y	'es 2 □ l	No						
DIVISION	or At after d Direct in by	Certification:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)						28f. Location (Street and Num City or Town, State)			Number or Ru	er or Rural Route Number,		
_	To the Hospital or Attending Physician: The I within 24 hours after deal! To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical Co	29a. Certifier 1 Certifying P (Check only one)	hysicien: To the best miner: On the basis o and manner sta	f examination	dge, death and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the ca	use(s) a	and manner as place, and due	stated. to the cause(s)		
	o the	Med	29b. Signature and title of certifier	A marino sta	u.50.		29c	. License	number		29	d. Date	signed (Monti	n, Day, Year)		
	1		30. Name and addressed person who completed cause of death (Item 23a) (Type, Print)  OR GARY LITTLE 300/ Hospital's Signature  31. Date filed (Month Day Year)  32. Registrat's Signature													
	GAN		30. Name and address of person who	completed cause of d	leath (Item 23	Ba) (Type,	Print)			Carri	FRIY MI	) 24	185			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	HosP rar's Signature	9,,-(2)				UNICY	1	00	100			
	Registr		OCT 0 3 2006	leen *	Aport											

State of Maryland / Department of Health and Mental Hygien 2 0 0 5 32710 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 09/30/2006 11:00 P Albert Reves /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ft. 10934 Riverview Road Washington Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□F Yrs. Director 566-09-6658 92 4/14/1914 Mexico Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itame 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Prince George Ft. Washington Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10934 Riverview Road USA 20744 within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: or h 1 Never Married 2 Married ¹\XYes 2□No Specify: Mexican ģ Specify: Hispanic 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Self-employed 11th other permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Itam 27 Is marked other eny injury or other treumatic event, 9058. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casillas Bernard Reyes Gabrina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10934 Riverview Rd. Ft. Washington, MD. 20744 Alberta M. Reyes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/3/2006 Edgewater, Maryland Kalas Crematory 21. Signature Funeral Service Licensee 22. Name and Address of Facility Geo. P. Kalas Funeral Home alda 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause / n each line. Immediate Cause (Final disease or condition resulting in death) CANCER Physician PROSTATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of the ettending physiclen and the for use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Physician/Medical d. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig pege 2 should b 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 ☐ Yes 2 XNo or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or Ai within 24 hours after of To the Funeral Directompletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSI CIAN D53590 OCTOBER 2, 2006 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 N BROADWAY SYDNEY DY, MO ROOM 609 ND 21205 BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 CT 0 2 2006 State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		•	State of Maryland / Department of Health and M  1 - State Registrer Certificate of Death		jien <b>2</b> 0 0 6	32711					
			1. Decedent's Name (First, Middle, Last)	2. Date of Dear		3. Time of Death					
	Physicia /Medic		Fibort Lorgin Killey Locations Locations A. August								
	Examin	al District County of Death									
			105 Jasper Riley Road Oakland		Garrett						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  None 1 O 1 O 1 O 1 O 1 O 1 O 1 O 1 O 1 O 1	8. Date of Birth (Month, Day	, Year) Col	place (State or Foreign ntry)					
	Director	-	220-40-1343 62 TIS. Usual Residence of Decedent	May 30	, 1944   Wes	t Virginia					
	ow ow	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	Many Figh	į	MD Garrett Oakland			1 ☐ Yes 2 No					
	h the	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of What Cou	intry?					
	th wit	aD	105 Jasper Riley Road 21550		United Sta	tes					
	ams arms	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White						
36	or It	포	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🛣 No tryes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify:	• •					
21215-0036	hour tural	ed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/l	ite					
5	in 72 in mar	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ina	Montgomery	*					
72	i with	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 Civilian Employee		Police Dept						
ਰੂ	be filed within 72 hours after deeth with the Maryland tal Hygene. ad Other than "natural", or Itams 23a or 28a-f show of other than "natural", or Itams 23a or 28a-f show event, the Medical Examination usit to notified a	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Sumame)						
Maryland	Aenta herra	To E	Harvey M. Riley Edith		Lee						
ary	and h	. 1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run								
Σ	and 2 ealth n 27 I		Mrs. Elizabeth Riley, Wife 105 Jasper Riley Road								
ore	of He	00000	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		20c. Location - City or 7	own, State					
Ē	ment tant: Jury c		`4 Donation 5 Other (Specify) Pleasant Valley Cemetery	10/6/06	0akland,	MD					
Baltimore,	permit. Peges 1 and 2 should be illed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other treumatic event, the Madical Examination at the Intitied at angles.				rst Funeral						
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arr	Oakland, MD	Approximate					
	Dharistan		shock, or heart failure. List only one cause on each line.	01	0	Interval Between Onset and Death					
	Physician /Medical		temediate cause (Final disease or condition resulting in death)  a.   Mutastatic adous (Caranoma Due to (or as a consequence of):	(N III	ng	6 months					
	Examiner										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):							
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events c								
oʻ	e exe	EX	resulting in death) Last  Due to (or as a consequence of):								
8760,	cate be executed physicien end the burial-transit	dical	d								
9	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		god Data of dali						
Box	death certifi e attending id for use as	lan	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deli Month	Day Year					
o.	that the death certifued by the attending detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown								
0	The law requires that the see has been signed by the page 2 should be detache	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?					
ds	ulres t	d by	moertention, emphipema	115/2	es 2□No 3□Pro	bably 4 Unknown					
00	w requir	lete		24a. Was a		opsy findings available					
Re	The lavelete has	ompleted		autop perfor		ompletion of cause of 2 No					
tai		O	25. Was case referred to medical 26. Place of Deat								
of Vitai Records,	S	To B	examiner?  1   Yes 2   No	ome 5 Kesid	lence 6 Other (Spec	ify)					
0			27. Manner of Death 1 ★Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred						
Sio	Attending r death. ector: Afte by the fune	catl	2 Accident investigation M 1 Yes 2 No								
Division	il or Attend efter death   Director: /	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	itreet and Number or Ru n, State)	rai Houte Number,					
	Hospital or 4 hours efte Funeral Oliv tely filled in I	O	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the	Palise(s) and manner as	stated					
	To the Hospital or Attentwithin 24 hours effer death To tha Funeral Director: completely filled in by the	edical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, o	date and place, and due	to the cause(s)					
	To the within 2 To the comple	Me	29b. Signeture and title of certifier 29c. License number		29d. Date signed (Month	, Day, Year)					
			Margaret a Lan m 026050	- (	10-2-200	6					
			1								
		,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 .	/	- A					
		6		land.	nd 215	50					
	Sta Registi	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ganeth  Margareta kaiser, ud 13074 highway, Ould  31. Date (Ind (Month) (1979) 3 2006) 32. Registrar's Signature	land,	md 215	50					

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Harry Reinhard Remmers September 29 2006 11:50 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. | Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 → M 2 □ F 81 Yrs. October 12,1924 Director 146-18-6858 PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f ehow permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f ehovany injury.co other traumatic event, the Medical Examiner must be notified at ence. 1 ☐ Yes 2√ No Directo Maryland Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2509 Mason Street 20902 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Television Engineer Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Henri Remmers Helen MacKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Mason Street, Wheaton, MD 20902 Helen M. Remmers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. Oct. 3, 2006 Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) led by the ettending physicien and detached for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed Atrial Fibrillation resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐Pregnant at time of death 5 Other (specify) Ö 9□ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, certificate has been sign rector, page 2 should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2X No After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1X Natural Injury 5 Pending efter death.

Director: Aft
J in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitei or within 24 hours el To the Funeral D 29a. Certifier Medical 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 09/29/2006 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 1500 Forest Glen Rd., Silver Spring, MD 20910 Α. Hynes Melisea 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 02 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registra MEND#23a(b)penMD10/10/06, BW.McCo Certificate of Death Reg. No. 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Daniel RACHEFSKY September 28, 2006 10:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park 4c. County of Death Montgomery Examiner Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 81 Yrs. Months Days Hours Min. Ma(Month, Day) 925 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F 579-38-8917 Director Washington, DC Usual Residence of Decedent Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Deparment of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural" or items 23s or 28s-1 show
any njury or other traumatic event, the Medical Evaninar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director Maryland Montgomery Olney 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 2905 Covered Wagon Way 20832 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: WW II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 X No white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Businessman Drapery Business 12 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca Halper 17. Father's Name (First, Middle, Last) Carroll Rachefsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1734 P St., NW, Washington, DC 20036 Eric Tobin, Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 10/03/06 Olney, MD 21. Signature of Yuser | Sprvice Lict nsee Torchinsky Hebrew Funeral Home 23a. Parti Farer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 254 Carroll St., NW, Washington, DC Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Doset and Death Sep5 15 **Physician** /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Completed by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed? 2 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5+1

P.O. Box 68760.

Records,

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Sung-Chieh Chen, M.D., 15225 Shady Grove Road, #201, Rockville, MD 20850

10064279

#### Please Type or Print in Black Indelible Ink

06-07615 State of Maryland / Department of Health and Mental Hygiene Charles R. Rye, II Certificate of Death 1- For State Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 9, 2006 1430 hrs Medical Examiner Charles R. Rye, II 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Gaithersburg Montgomery 24 O'Neill Dr. Apt 1 If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Director Country) Maryland Yrs 4/17/1955 1 X M 2 F 219-68-2718 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location ΠŽ 10h County Yes 2 No 28a-f show Maryland Montgomery Gaithersburg with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number 23a or 24 O'Neill Drive 20877 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes White after ( If Yes. Give Year 1 Yes 2 X No specify: Specify: 4 Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ the Medical Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene ant: If item 27 is marked other than 9 Baltimore, MD 21215-0036 Biotech Truck Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Helen Mayhew Charles Russell Rye, I 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4220 Bill Moxley Rd., Mt. Airy, MD Gayle H. Davis/Sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Department of He Important: If ite injury or other t crematory or other place) Burial 2 X Cremation 3 Removal from State verdale Park 4 Donation 5 Other Specify 10/10/2006 Riverdale. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, 21. Signature of Funeral Service Licensee 20910 M00956 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Hypertensive cardiovascular disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED item#23a,27,perME,g861,11/8/06 TT physician a Box 68760, 23d, Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Year attending past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown by the atte Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Hospital. 1 Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 1 Yes 2 No 5 Pendina the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) within 24 hours a determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME. October 10, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) Figistrar's Signatur State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Imogene Agnes Remsberg September 26, 2006 5:50 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 33 Main Street Walkersville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 72 220-30-7771 Yrs Director September 14,1934 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-1 show the Medical Examiner must be notified at Maryland Frederick Walkersville 1X Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 33 Main Street 21793 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: white 34 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other this any Injury or other traumatic event, Item 2008. 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Main Frances Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Remsberg - son 33 Main Street, Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glade Cemetery 9-30-2006 Walkersville, Maryland 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwo Immediate Cause (Final disease or condition resulting in death) ear **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Mospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) ettending physicien for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probebly 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **N**o 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation I Director: / 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and 29d. Date signed (Month, Day, Year) cause of death (Item 23a)\_(Type, Print) 7th street SKanders MI 501 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State	State of Ma	arylar			nt of H te of L		and Me				327	16	
			Registrar  1. Decedent's Name (First, Middle, La	st)				.0 0, 1	- Catil		2. Date of Dea	th			Death	
	Physici		TEMMETER NATIONAL CONTROL								Month SEDTEMB		6 2.3	36P <sup>M</sup>		
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location o		714 11111		4c. County of Death			
13			SOUTHERN MARYLAN			last birthday)			INTON			Reg. N2 0 0 6 3 2 7 1 6  Tof Death th Day Year 7  TEMBER 24, 2006 2: 36P 4c. County of Death PRINCE GEORGES  of Birth 1th, Day, Year) 9. Birthplace (State or Foreign Country) 14, 1947 NORTH CAROLINA  10d. Inside City Limits XX Yes 2 1 No  10g. Citizen of What Country?  UNITED STATES  or No- tc.) 14. Race - American Indian, Black, White, etc.  Specify: BLACK  16b. Kind of Business/Industry  ALIST GW UNIV. HOSP.  Middle, Maiden Sumame)  ENumber, City or Town, State, Zip Code)  ORT WASHINGTON, MD 20744  20c. Location - City or Town, State  06 SUITLAND, MD  OME OF MARYLAND, INC.  SUITLAND, MD 20746				
	Funeral		5. Social Security Number 6. S	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	, Year)	Year) Country)						
	Director		578 60 6250 A			59 Yrs.	L			Į E	AUG. 14	, I	94/ NUK	TH CAROL	_INA	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation									
	ith the Marylar or 28a-f ehow re notified at	ctor	MD PRINCE GEORGES FORT WASHINGTON									XIXIYes	2 🗌 No			
	vith th	Director	10e. Street and Number				10f. Z	ip Code			1	10g. Citi	zen of What Co	ountry?		
	sath v	era	5908 GLEN ROCK A	VENUE #101	Ever in I	S 12	Was Dec	2074	<u> </u>	nin? (Spec	ify Yes or No-					
<b>,</b>	fter d	Funeral	1 Never Married XX Married	Armed Forces?  NXYes 2		.5.	If Yes, sp	ecify Cuba	n, Mexican	, Puerto R	ican, etc.)		Black, Whit	e, etc.		
ő	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Exeminer must be notified at	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🖵 Yes	XXNo	Specify:				Specify: BL	ACK		
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	kind of w	ork done a	luring most	t of working	g	16b. Ki	nd of Business	/Industry		
12	within	idm	Elementary/Secondary (0-12)	College (1-4or				use retired		a ani	2014110	m /	Orr 1131777	HOAD		
Maryland 21215-0036	Hygie Hygie ther		17. Father's Name (First, Middle, Last	2YRS	•	MEDIA	LAB	UPER						. HOSP.		
an	lid be lental ked o	To Be	JIMMY SMITH						ODES	SA HO	OWIE					
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Addre	s (Street a	and Numbe	r or Rural	Route Number	r, City o	r Town, State,	Zip Code)		
	ges 1 and 2 should be filed within 72 hours after death with the Maryla tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examiner must be notified at		FENNIE GEE SMITH	/ WIFE					AVE.		-				744	
Baltimore,	Pages 1 nent of H int: if iter iry or oth		20a. Method of Disposition  XX Burial 2 Cremation 3 [	Removal from State	20b. F	Place of Dispo cemetery, crei	sition (Nation)	ame of other place	1	Da						
<u>=</u>	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	-	CEI	DAR HII					_					
Ba	permit. Page Depertment of Important: if eny injury or once.		21. Signature of Fullerian Service Co	142	MARSHALL'S FUNERAL 4308 SUITLAND ROAD											
			23a. Part1. Inter the disease, or con	plications that caused	the deat	th. Do not ent							, עדו פעוי	Approximate		
	nysician		shock or heart failure. List only Immediate Cause (Final disease or condition			MYO	CA	2DIA	<i>c</i> 1	NFA	trecT.	no	)			
	/Medical		resulting in death)	Due to (or as			- 47		_		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,10				
	Examiner	L	Sequentially list conditions,	b												
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	(uence or):										
<b>_</b> ,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consec	uence of):	<del></del>									
8760,	cate be executed obysician and the burial-transit	dicai	(	d.												
89	ng ph	Med	IF FEMALE:											_		
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	ıl death 3 □		pregnancy				1 2		,	ear	
P.O.	that the death certific ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	t time of c	leath 5	Other (	specify)						/		
σ.	that I	y Ph	Part II. Other significant conditions	contributing to death b	ut not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of de	ath?	
rds	w requires that been signed by should be det	ed by	HYPERTI	MSION							1 □ Y	es 2[	□No 3 1	robably 4 Dur	nknown	
00	law reason bee	piet									24a. Was a		24b. Were at	utopsy findings a	vailable	
24a. Was an autopsy performed in the state of the state o								med? 2 No	death? 1 ☐ Yes		036 01					
/ita	icien: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?	11				I au		of Death	(Check only or	ne)				
<del>_</del>	Physi this o	۲.	1  Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatier 28b. Time o	-		4 🗀 NU				6 Other (Spe	ecify)		
O	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	28c. Injury Work	(? /es 2 □ }		28d. Describe how injury occurr					
0 1 2 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of								ry, office		28	Bf. Location (S City or Tow	on (Street and Number or Rural Route Number,				
ā	o ete o	Cert	4 [] Hollheide	building, er	c. (Speci	· <b>y</b> /					City of Tow	n, State,	,			
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	(Check only 2   Medical Exa	hysician: To the best miner: On the basis o	f examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim	ie, date and pinion, deat	d place, ar th occurre	nd due to the c d at the time, c	ause(s) date and	and manner as place, and due	s stated. to the cause(s)		
	To the within 2 To the complet	Med	one) 29b. Signature and title of certific	and manner st	ated.		2	9c. License	number		2	29d. Dat	e signed (Mont	h. Dav. Year)		
)	8 7 8 1		1-100 RUF						324	†				25,20	06	
0	(4)		30. Name and a dress of person who	completed cause of o	death (Iter	п 23a) (Туре.	Print)			2				0.		
1	2		TERREY	200 STELL	n. D.	750	354	IRRA	175	ROA	0, CL	INT	on, ma	RYLAN	D	
	Sta Registr		31. Date filed (Month, Day, Year)  CFD 2. 9. 200	2. Registr	ar's Sign	ature La	110									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Tyrese Emerson Simmons

		1- For State Certificate of Death Reg. No. 2005 32/1											
Physicia		Decedent's Name (First, Middle,Last)  2.	Date of Death		3. Time of Death								
ledical Exami	ner	TYRESE EMERSON SIMMONS	Month [ S <b>eptember</b>	Day Year 26, 2006	1750 hrs								
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	ath								
		3400 Toledo Terrace Apartment J3 Hyattsville		Prince Geor	ge's								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Months Days Hours Min.	s. Date of Birth	(MM/DD/YYYY) 9. E	eign								
Director	- 1	247 59 3293   1XM 2 F   24 Yrs   World's Days   10015   Will.	02/26/1		Country)PENN.								
	ŀ	Usual Residence of Decedent											
any	ı	10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits								
À		DELVE CECECO VEREN VIENNES			1 X Yes 2 No								
Aaryland 28a-f show 1 at once.	ট্	MD PRINCE GEORGES UPPER MARLBORO	1.0	611									
Many 28a dat	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	ountry?								
a or tiffe	盲	13095 SALFORD TERRACE 20772		UNITED S	TATES								
with s 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	ify Yes or No-		erican Indian, Black,								
ath item	힐	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	White, etc.									
er de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: B	LACK								
s afi	2	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of works)	k dono	6b. Kind of Busines									
2 hours af "natural" I Examin	Completed	during most of working life, DO NOT use retired		OD. Killd of Busilles	s/industry								
136 hin 72 e than "	흵	Elementary/Secondary (0-12) College (1-4 or 5+)											
0036 within 72 iene er than Medical	Ē	12TH LABORER		PRIVATE									
5-00; led with Hygiene other ti	ပို	17. Father's Name (First, Middle, Last) 18.Mother's Name (Fi	irst, Middle, Ma	iden Surname)									
21215-0036 uld be filed within 7 Mental Hygiene marked other than r event, the Medica	Be	EMERSON COOLEY MELLEANE	SIMMO	NS									
Me ma	ဥ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rura	al Route Numb	er, City or Town, Sta	ite, Zip Code)								
MD 21215-0036  d.2 should be flick within 72 hours after death with the Maryland this and Mental Hygiene no 77 is marked other than "natural", or items 23a or 28a-fish unartic event, the Medical Examiner must be notified at once	- 1	MELLEANE SIMMONS-CONYERS/MOTHER 13095 SALFORD TERR. UP	PER MAI	RLBORO, M	D 20772								
ore, MD 2121; ss I and 2 should be file of Health and Mental F If item 27 is marked her traumatic event,				20c. Location - City									
St Les 1		1 X Burial 2 Cremation 3 Removal from State crematory or other place)											
Pag Pag nent ant:		4 Donation 5 Other Specify: ANDERSON MEMORIAL GARD. 10/	02/06	ANDERSON	, SC								
Baltimore, I permit. Pages I and Department of Healt Important: If item injury or other tra	- 1	21. Signature of Funeral Service Licensee ARSHALL S FUNERAL	HOME (	DE MADSELAI	NID TNC								
1. T & g		4308 SUITLAND ROAD	SIII	TLAND, MD	20746								
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re			Approximate Interval								
/Medical		failure. List only one cause on each line.			Between Onset and Death								
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			25341)								
, <i>j</i>		or condition resulting in death)  Due to (or as a consequence of):											
	اب	Sequentially list conditions,			+								
	. <u>e</u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
	Examiner	events resulting in death) Last Due to (or as a consequence of):											
ted J ansit		d d											
8760, rificate be executed ng physician and as the burial - trans	Physician/Medical	UNPENDED AMENDED											
760, icate be ewe physician graph the burial -	훘												
8760, tificate being physic as the bur	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	·								
68 certifi	jä	past 12 months? 2 Fetal death 3 Ecopic pregnancy	У	Month	Day Year								
Box 6: death cert	Sic	1 Yes 2 No 9 Unknown 9 Unknown			1								
ne de m	ž	3 UNINGWII	Too- Distant	I									
P.O. es that the igned by	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 _		to the cause of death?								
res that signed			1 Yes	2 No 3 P	robably 4 Unknown								
Records, The law require ficate has been si	Completed		24a. Was an		autopsy findings available								
law has t	힏		autopsy perform		o completion of cause of								
Rec The licate licate	팃		1 <b>Y</b> Yes 2										
tal Recian: The	au l	25. Was case referred to medical 26.Place of Death (Check only	y one)										
Division of Vital tal or Attending Physician is after death.  al Director: After this certical in by the funeral director.	œ e	examiner?  1 ✓ Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing H	lome 5 R	esidence 6 🗸 Oth	ner: Scene								
of of ing Phy After the	.T	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28	d. Describe ho	w injury occurred									
e firm	Certification:	Pending 1 ONB. 1 Yes 2 No	ibject shot										
SiG dear	cat	2 Accident Investigation Sep 26, 2006 1732 hrs	of 1		D and D and a Cit								
A Brief	#	Suicide Could not be	or Town, Sta	te)	Rural Route Number, City								
Dipital ours a filled	ē	T. C. Marie	00 Toledo	Terrace, Hyatts	ville, MD								
Hos 24 h Fuir tely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and during the control of the											
Division of Vital Records, P.O. Box 6 within 24 hous after death certwinin 24 hours after death. The law requires that the death certwinin 24 hours after death. The this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the	ne time, date ar	nd place, and due to	the cause(s)								
F × F S	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (A	Month, Day, Year)								
		O.C.M.E.		September 27,									
		Chief C			2000								
010 (5)		30. Name and address of person who completed cause of death (Item 23a)											
Clark		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
St	ate												
Regis	rar	SEP 2 9 2006 Common April 2006											

			For State Registrar	State of Maryland	/ Depa	rtment of tificate of	Health a Death			sg. 140.	06	
<b>44</b> 8	Physici		Decedent's Name (First, Middle, Last)     MARGAR	ET MCKENNEY ST	UDEVEN	ΙΤ			Date of Deat Month SEP 24	Day	Year	3. Time of Death  1:33 AM
	/Medic Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,		of Death		4c. County	of Death	PDV
~ 4 6			NATIONAL NAVAL MED 5. Social Security Number 6. Sex		st birthday)	BETHE If Under 1 Yea	r If Under	24 Hrs. 8	. Date of Birth (Month, Day,			lace (State or Foreign try)
	Funeral Director			M 21XF 75	Yrs.	Months Days	s Hours	Min.	(Month, Day, 19. 14.	1931		ginia
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Loc	ation					1	Od. Inside City Limits
	e Maryli ta-f sho	ctor	Maryland Prince G	eorge's		Capit	tol He	ights				1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			1	0g. Citizen of 1		,
	sath v		1404 Nye St.	12. Was Decedent Ever in U.S	13 W	as Decedent of	2074		fy Yes or No-		ited :e - Americ	States an Indian,
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural, or ltems 23a or 28a-f show imatic event, the Medical Examination must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	lf .	Yes, specify Cu	ıban, Məxican	i, Puerto Rii	can, etc.)		ck, White,	
21215-0036	2 hou	ted	15. Decedent's Edui		16a. Decede	ent's Usual Occ	upation	t of working		16b. Kind of B	usiness/Inc	fustry
7	ithin 7 19.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retii	rød)					
7.7	lied w Hygier ther th	Col	12th  17. Father's Name (First, Middle, Last)		Phys	ical The				Gove Maiden Suman	ernme na)	nt
Maryland	ld be lental l	To Be	Leonard Bo	x1ey					Dora	McKenne	еу	
ary	ts be the	-	19a. Informant's Name/Relationship (Ty	рө, Print)		g Address (Stree				-		Code)
	and 2 ealth a m 27 ls		Brian A. Studeve			Dutch V		e Dr.,	-			785
altimore,	permit. Pages 1 Department of H Important: If itel sny injury or ott		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State		ition (Name of atory or other fi Nationa		10/13/		20c. Location - Ar1i1		
a	mit. F partme portar y injur		21. Signatur of Fun ral Service License			Name and Add			tewart	Funera:	l Hom	e
ñ	99 E 2 8		John !	Slewart 1			Benni	_		Wash.	, DC	20019 Approximate
-	Physician / Medical Examiner supplies the prival-transit	Examiner	23a. Part1. Enter the disease, or complishock, of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ASTIC ence of):							Interval Between Onset and Death
8760,	ysicier e burii	dicai E		<b>.</b>								
Box 6	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3 🗌	Ectopic pregnar Other (specify)				1	ite of delive	ery Day Year
ת. מ	s that ined by e deta	by Ph	Part II. Other significant conditions con	ntributing to death but not resul	iting in the un	derlying cause	given in Part I		23e. Did tol	bacco use con	tribute to th	ne cause of death?
ord S	w require been sig should b	tedt							1 🗆 Y	es 2 X No	3 Prob	ably 4 Unknown
Reco	The law rate has be page 2 sh	Completed				· · · · · · ·			24a. Was a autops perform	med?	Were auto prior to co death? 1 \( \subseteq \text{Yes}	psy findings available mpletion of cause of 2 No
/ita		Be	25. Was case referred to medical examiner?	face was				e of Death (	Check only on	18)		
Division of Vital Records, P.O.	Phys r this ral di	lon: To	27. Manner of Death 1 🛣 Natural 5 🗀 Pending	lospital: 1 Minpatient 2 E 28a. Date of Injury (Month, Day Year)	R/Outpation 28b. Time of Injury	28c. In		28	· · · · · · · · · · · · · · · · · · ·	ence 6 Otl		y)
Divisio	l or Attending after death. Director: After in y the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre				of Location (Since City or Town		ber or Rura	i Route Number,
	the Hospital nin 24 hours a the Funeral I	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the restigation, in m	time, date ar y opinion, dea	nd place, an	id due to the c d at the time, d	ause(s) and m late and place,	anner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7		29c. Lice	ense number		2	29d. Date signe		
)			) / 1 / h	mn		01	012367	02 (V	A)	septe	wher	25, 2006
V	2(4)			on Ale cause of death (Item		Print)			AVAL MI D 20889	EDICAL	CENTE	R
1	St	) le	CHRISTOPHER S. K. 31. Date filed (Month, Day, Year)		USA ure		DETHE	N AUG	ט עטסט:	-2000		
	Regist		SEP 2 9 2006	32. Registrar's Signati	Brooks							

		•	For State Registrar	State of Marylan	id / Depa		Health and N	Mental Hy	_	32719
.6	Physicia	an	1. Decedent's Name (First, Middle, Last)	Latimer Under	wood Si	hearard		2. Date of De. Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give s				or Location of Death	-	4c. County of Dea	-
П	Examin	er	601 East Randolpl		107	Silver			Mont	gomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		rthplace (State or Foreign country)
- 5	Director		098-20-6406	]M 2 <b>X</b> F 80	Yrs.	Months Days	Hours Min.	December 1	er 11, Sou	th Carolina
poelview the Maryland	Additional transfer of the management of Mental Hygiene and Mental Hygiene and Medical Examiner man be notified at matic event, the Medical Examiner man be notified at	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
N e	Ba-f	Director	Maryland Montgo	nery	Silve	r Spring				
Ę	or 2	Dire	10e. Street and Number		107	10f. Zip Code			10g. Citizen of What C	
t d	23	Funeral	601 East Randolpl	<u>-</u>		2090			United Sta	
	Tem.	nne	11. 11.	12. Was Decedent Ever in U Armed Forces?	.5. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
.0036	io.	by F	1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B	Lack
	le di E		15. Decedent's Edu		16a Dece	dent's Usual Occu	nation		16b. Kind of Business	s/Industry
1215-	a dia	jete	(Specify only highest grade	o completed)	(Give	kind of work done DO NOT use retire	during most of world)	king	Heat Sea	·
7	the diameter	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  2 years		ok Keepe			Noveltys	
Q 5	Hyginther and	ပိ	17. Father's Name (First, Middle, Last)	z years	1 10	ok keepe.		e (First, Middle,	Maiden Surname)	
, man	and Mental	To Be	Roy Latimer				Sylve <sub>1</sub>	ne Jo	hnson	
<u>7</u>	Depertment of Health and Mental Important: If Item 27 is marked any Injury or other traumatic events.	-	19a. Informant's Name/Relationship (Ty	pa, Print)	19b. Maili	ng Address (Stree	and Number or Ru	ral Route Numbe	ar, City or Town, State,	Zip Code) 10029
<b>S</b> S	27 ls 27 ls r trau		Sandrena Underwood	d Crews					York City,	
Baltimore,	Hea		20a. Method of Disposition			osition (Name of matory or other pla		Data	20c. Location - City o	
mor	y or		1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	iemovat from State		Heaven Co		,2006	Silver Spr	ing,Maryland
	ortan Injur		21 Signature of Funeral Service License				and the second s			
ä	Ded you		1 Sandalash	RAL	25	R. N. Hot	rton Compa	ny Mort	icians, In ashington,	D.C. 20011
			23a. Part1. Enter the disease, or compli	ications that caused the deat						Approximate
46			shock, or heart failure. List only or fmmediate Cause (Final	ne cause on each line.			41		1	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	. Central Ner	wes S.	ystem M.	etastores,	Unspec	itied	42 months
	xaminer		- 1	Due to (or as a consec	quence or):			·		
		_	Sequentially list conditions	Due to (or as a consec	uence of):					
2	isit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,					
	and al-tra	хаг	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
760,	lysicien and he burial-transit	calE								
	phys s the									
X	attending phy	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy				23d. Date of de	alivery
Вох	atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3[	□Ectopic pregnand □ Other (specify) _	Ey .		Month	Day Year
O. 1	the	ysic	1 □ Yes 2 <b>X</b> No 9 □ Unknown	9 Unknown	304(11 3)	_ Other (specif) _				
مَ عَ	ed by the a	by Physician/Med	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	ınderlying cause g	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Records, P.O. Box 68	signed be del							10	Yes 2 □ No 3 □ F	Probably 4X Unknown
ס פֿ	been si	Completed						04- 146-	[au w	
Sec.	has l	ıμ						24a. Was	osy prior to death?	autopsy findings available completion of cause of
		ပိ						1 ☐ Yes		s 2 No
of Vita	tending riferials. In the tuneral director, page	Be	25. Was case referred to medical examiner?	Hospital:		10	26. Place of Dea	th (Check only o	one)	
Of .	this d	ြ	T Tes 250 No	1 tnpatient 2	ER/Outpatie	III 3 DOA			dence 6 Other (Sp	ecify)
C 2	After	on	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time o Injury	Wo		Zou. Describe	now injury occurred	
vision	tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Diagraphic Att			]Yes 2 □No	29f Legation /	Street and Number or I	Dural Paula Number
Division of Vital Records,	after death	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)	reet, factory, office		City or To	Street and Number or F vn, State)	nurai moute Number,
	hours a uneral D		20e Codifier (M. Codifier To	plaine. To the best of and to	audadaa da	th engine	data and -1:	and due 4 - 45	anuna(a) and air	an alated
3	Funeral	Medical	29a. Certifier 1 A Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and du	ue to the cause(s)
4	ie <b>t</b>	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
1 /	2 0 0									
/	6)		Paul bannen	ampleted saves of death (b)	- 02-) (T		60335			2006
	20		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,			_	rive; Suit	e 321
	X/	10	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Oute	y, Marylaı	id ZUS	) <u></u>	
	Sta Registi		OCT 0 3 2006	due 1/4 de	and o					

Startt

Rachel

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending irector, page 2 should be detached for use as within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director,

		For State		State o	f Maryla	nd / Depa	artment rtificate				lental Hy	0	00		22720
		Registrar     Decedent's Name	e (First, Midd	le, Last)		001	inicate	01 0	Call		2. Date of De	Reg. No.	UUI	0	3. Time of Death
Physici		RACHEL									Month Oct	Day 2	200	ear 6	12:45 AM
/Medic Examin	a			n, give street and nu	mber)		4b. City,	Town, or L	Location	of Death	000	4c.	County of		12.45 AH
		Genesis	Heal	lthCare -	- The	Pines		Eas					Та	lbc	ot
uneral irector		5. Social Security N <b>213–01–82</b>		6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi Month D AUG 29	rth ay, Year) • 191	L <b>7</b> 1		lace (State or Foreign ITAND
\$ 1350 E		Usual Residence of 10a, State	Decedent 10b, Count	,	10c. C	City, Town or Lo	ncation							1	0d. Inside City Limits
sho	ō				100.0									'	1 X Yes 2 □ No
28e-1	Director	MD 10e. Street and Nur		BOT		r.	ASTON 10f. Zip	Code				10a Citi	zen of Wh	at Coun	atry?
3a or	ā			TANT			70.1.0.1		1601			, og. 0 i.i		USA	,
ms 2	Funerai	11. Marital Status	CHIANS	12. Was Dec	edent Ever in	U.S. 13.	Was Deced	ent of His	spanic Or	rigin? (Spe	ecify Yes or N	0-	14. Race -	Americ	an Indian,
f, or its	by Fur	1 Never Marri	_	1/1/ 0:	2 <b>X</b> No ve		if Yes, spec 1 □ Yes 2		Specify:		Rican, etc.)		Black, Specify:	White,	
ealE	ed		15. Decede	nt's Education		16a. Dece	dent's Usua	I Occupat	tion			16b. Ki	nd of Busir		
Mad.	Completed	(Speci Elementary/Seco	ify only highe	est grade completed) College (	1-4or 5+)	(Give	kind of wor DO NOT us	k done du	uring mos	st of worki	ing				,
ar th	mo:	11	(U-12)	0		S	ECRETA	ARY				STAT	CE HE	ALTI	H DEPT.
d oth event	Be (	17. Father's Name	(First, Middle	Last)					18. Moth	er's Name	First, Middle	, Maiden	Sumame)		
atic	J.	EMORY R								ALICE	RYAN				
27 is m treum		19a. Informant's Na		ship (Type, Print) DAUGHTER			_				Noute Numb			ate, Zip	Code)
other		20a. Method of Disp			20b.	Place of Dispo	sition (Nam	ne of			Date		cation - Ci	ty or To	wn, State
nt: If		1 🔀 Burial 2   `4 ☐ Donation		3 □Removal from Specify)	State S'	cemetery, crea L. JOSE	-		′ I	10/	7/2006	COI	RDOVA	. M/	ARYLAND
Importent: if item 27 is marked other then "neturef", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signature of Fu	neral Service	Licensee		F F	Name and	d Address	s of Facili	NBEIN	& NEW	NAM 1	FUNER.	AL I	HOME PA
		1		Ostrow.		2.5.12	00 S.	HAR	RISON	N ST	EASTON	, MD	2160	1	
		shock, or hea	rt failure. Lis	r complications that of t only one cause on o	each line.	ath. Do not en	er the mode	e or crying,	, such as	s cardiac o	or respiratory a	arrest,			Approximate Interval Between Onset and Death
sician		Immediate Cause ( disease or condition resulting in death)		a	ardi	popula	rathy								years
ledical aminer		Tooling in dollar,		Due to	(or as a conse	equence of).		1	0.7	-1				6	
	<u>-</u>	Sequentially list co	nditions,	b. Due to	(or as a conse	equence of):	515, 4	men	19150	ed .		-		1	geers
nsit	nin.	cause. Enter Unde Cause (Disease or	injury	<	(	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0								
n and al-tra	Examiner	that initiated events resulting in death) i	Last	c	(or as a conse	equence of):									
physician and the burial-transit	dicai			d											
മെ ജ	- W														-
attending p	Physician/M	IF FEMALE: 23b. Was deceden		23c. If yes, ou	tcome of preg		Ectopic pre	ennancy				12	23d. Date o		*
he att ed fo	sicis	in the past 12	No		ant at time of		Other (spe						Month		Day Year
f by tl etach	Phy	9 Unknown				- Turk									
be d	by	Part II. Other signif	A	ions contributing to d	eath but not re	sulting in the u	nderlying ca	ause giver	n in Part I	I.					ne cause of death?
een s	eted	#	14.	visori_							1	Yes 2[	□ No 3	☐ Prob	ably 4 Unknown
hasb e 2 sl	Completed	Deme	nta								24a. Was	psy	pric	or to cor	psy findings available npletion of cause of
cate , pag	Cor										1 ☐ Yes	ormed? 2 No		th? Yes	2 No
certifi	Be	25. Was case refer examiner?	_	Hospital:				Other			n (Check only	one)			
this ral dii	: To	1 Yes 2		28a. Date		ER/Outpatier 28b. Time o		A	4 NI	ursing Ho	me 5 Res 28d. Describe		6 Other		()
After	tlon	1 Natural	5 🗌 Pendi	/4.4ar	th, Day Year)	Injury	M	8c. Injury : Work?	? 'es 2 □		zod. Describe	riow injur	y occurred		
ctor: y the	fica	2 Accident 3 Suicide	6 Could	not be	of Injury - At	home, farm, st					28f. Location	(Street an	d Number	or Rura	I Route Number,
f Dire	Certification:	4 Homicide	deteri	build	ing, etc. (Spec	cify)	,				City or To	wn, State,	)		
To the tunner Director. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only	1 Certifyi 2 Medica	ng Physician: To the Examiner: On the b	asis of exami	nowledge, deat	h occurred a	at the time in my opi	e, date ar inion, dea	nd place, a	and due to the	cause(s) date and	and mann I place, and	er as st	ated. the cause(s)
mple	Med	one) 29b. Signature and		and man	ner stated.			. License			- T		e signed (/		
<b>₽</b> 8		•		MAST	,			777	259	53			10.7	2,0	7
		30. Name and addr	ess of person	n who completed cau	se of death (It-	am 23a) (Tuno	Print\	11	- / /				0 2	ارت .	<i>V</i>
-		MICHA	LCP	OW1:4 h			ישונים (	HMA	DINE	LA	NE /	EAS	TON	MI	21601
Sta	ate	31. Date filed (Mon	th, Day, Year	) 32 F	Registrar's Sig			11111	(' V )	17.1			,	1 14	1 ~140]
Regist	rar	00	T 0 3	2006	THE S										

				1 10030 1	State of M							ental Hyd	iene	ibic.		
			1 - For State Registrar		State of W	arytant				Death	LITCH IVIC		eg. No.20	06	327	121
			Decedent's Name (Fire	rst, Middle, Last)								2. Date of Dea Month	th	Year	3. Time of	
	Physici /Medic		Doris Lavi	nia Scot	tt							)CHCD81		€ 3000	C255	AM
	Examin	er	4a. Fecility Name (If not	-						Location o	f Death			ty of Death hingt	010	
199	Funeval		Washington 5. Social Security Number				ast birthday)		gerst	OWII If Under 2		8. Date of Birth (Month, Day			place (State or	r Foreign
	Funeral Director		217-28-705		M 2 <b>∏</b> F	74	Yrs.	Months	Days	Hours	Min.	Month, Day 01/24/1	, Year) 932	Cou	ntry) MD	
	pur *		Usual Residence of Dec	edent c. County		10c. City	, Town or Lo	cation							10d. Inside Cit	tv Limits
	Maryla	tor		Vashingt	on	1	lagers								1 <b>∑</b> Yes	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland naturent of Heelth and Mental Hygiene. ortant: If Item 27 is marked other then "natural; or Items 23a or 28a-f ehow injury or other treumatic event, the Medical Examiner rout be notified at injury or other treumatic event, the Medical Examiner rout be notified at a.	Funeral Director	10e. Street and Number 133 Broadw		#1				Code 1740			1	0g. Citizen of US	What Cou	ntry?	
	deat	ner	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)		ce - Ameri		
9000	ours after ursi', or it I Examin	Completed by Fu	1 Never Married 3 ☐ Widowed 4 ☐	Divorced	1 ☐ Yes 2 <b>X</b> If Yes, Give Year or Dates:			1 🗆 Yes	2 X No	Specify:			Speci	ity: B	lack	
15-	n 72 t	olete	(Specify or	Decedent's Educ nly highest grade	completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ation <i>duri</i> ng most !)	of workin	9	16b. Kind of 8	Business/In	dustry	
212	d within giene. or then "	mo:	Elementary/Secondary	y (0-12)	College (1-4or	5+)		care					Nur	sing	Home	
and	12 should be filed within " h and Mental Hygiene. 7 is marked other then " Ireumatic event, the Med	To Be C	17. Father's Name (First Clarence F		ott							(First, Middle, e Isabe		,		
	ith and M.	-	19a. Informant's Name/ Anna D. So		oe, Print)		19b. Mailir 430	ng Address	s (Street a	and Number	or or Rural treet	Route Number, Hager	c. City or Town	n, State, Zij MD 2	.1740	
Baltimore,	of Heelth item 27 i		20a. Method of Dispositi			CO	ace of Dispo emetery, crer	sition (Namatory or o	me of other plac	e)	Da	ate	20c. Location	- City or To	own, State	
Ë	Page ment cant: If		1 ☑ Buriaf 2 ☐ Cri 4 ☐ Donation 5 ☐		emoval from State		se Hil	1 Cem	eter	y 1			Hagers			
Ball	305 N. Potomac Street, Hagerstown, MD 21740													Home		
shock, or heart failure. List only one cause on each line.  Immediate Cause (Finaf													Approximate Interval Bety Onset and D	ween		
	Physician /Medical		disease or condition resulting in death)	ır a	Acute			wdia	21	Int	arc	nan				
н	Examiner				Due to (or as	a consequ	ience or):									
	D =	ner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ons, diate g	Due to (or as	a consequ	ience of):									
	ecute and I-trans	Examiner	Cause (Disease or injur- that initiated events resulting in death) Last	y o	. Due to (or as	s a consequ	ience of):									
760,	be execut sicien and burial-tran	calE		l.	•	, a 001100qa	JOHOG 617.									
89	certificate iding phys			d												
P.O. Box	death e atter	Completed by Physician/Med	fF FEMALE: 23b. Was decedent prein the past 12 more 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ms?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[	∃Ectopic p ∃ Other (s)						ate of deliv Ionth	- /	Year
	requires that the een signed by th nould be detache	y Pt	Part ff. Other significan	t conditions con	tributing to death	but not resu	ılting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use cor	ntribute to t	he cause of d	leath?
ords	w require been sig should b	ted t	MRSA P	neume	nca -							1 🗆 Y	es 2 No	3 🗌 Prol	pably 4 🖼	nknown
Records,	aw as b	nple	ConGestin	re He	art to	elu	ξ	<del></del>				24a. Was a autop	SV	prior to co	opsy findings a ompletion of ca	available ause of
a F	Page T		B/L ple	wal	effici	015							2 No	death? 1 ☐ Yes	2□ No	
ξ		To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No		ospital: 1 Topati	ient 2 🗆 I	ER/Outpatier	nt 3 🗆 D	Othe	200		(Check only or ne 5 ☐ Resid		ther (Speci	fv)	
ا م	ding Phys h. After this funeral di		27. Manner of Death	Pending	28a. Date of Inj (Month, Da		28b. Time o		28c. Injun Worl			8d. Describe h			,,	
Sior	uttending death. ctor: Alter y the fune	catlo	2 Accident	investigation				М	1 🗆 '	Yes 2 □ I						
Division of Vital	ir b	Certification:	4 Homicide	determined	28e. Place of Ir building, a	ijury - At ho tc. <i>(Specify</i>	me, farm, sti	reet, factor	y, office		2	8f. Location (S City or Tow		nber or Run	al Route Num	ber,
	Hospitel	Medical			sician: To the besi ter: On the basis of and manner s	of examinat										;)
	within To the comple	Me	29b. Signature and title	of certifier	e agre	eeel	2	29	c. License	e number		2	9d. Date sign	ned (Month,	Day, Year)	
			HOS	PITTERS	T/Was	h CN	TY H	05P F	100	101	117	(	BCICBI	er	0,2	006
( 61	1-8		30. Name and address	of person who co	mpleted cause of	death (ftem	23a) (Type,		200	Λ Λ	A ()	2174	10			
	Sta	te	31. Date filed (Month D	ALTONTICE OF	32. Regist	rar's Signal	ture	yes!		~ 10		01/4				
	Registi		U	UI U 3 20	JUD Jean	ارعودا	1. 1	neck	)							

DHMH 17 Rev 1/2001

			For State Registrar	State of	of Marylan	d / Depa	artment of F	lealth a Death	nd Mental Hy	giene 00 (	5 32722				
e.F	Physici	an	Decedent's Name (First, Middent Clara Marie S						2. Date of De	ath	3. Time of Death 5:02 A M				
	/Medio		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, or	r Localion of		4c. County of E					
		<b>.</b>	Washington A				Takoma			Montgom					
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ <b>X</b> F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours 2	Min. (Month, Da	iy, Year)	Birthplace (State or Foreign Country)				
4	A		136-07-6178 Usual Residence of Decedent		00				August	4, 1918 N	New Jersey				
	trylan thow	_	10a. State 10b. Count	у	10c. City	, Town or Lo	ocation				10d. Inside City Limits				
	8a-1	Director		omery	s	Silver	Spring				1 Tes 2 No				
	with t	Dir	10e. Street and Number  5 Lauer Terra	CO			10f. Zip Code	901	ar i canada	10g. Citizen of Wha					
	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show ha Madical Exeminer must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.			in? (Specify Yes or No Puerto Rican, etc.)	USA 14. Race - A	American Indian,				
و	or Ite	Fur	1 Never Married 2 Ma	rned 1 Tes If Yes, Gi	2 📉 No		If Yes, specify Cuba 1 Tes 2 No	an, Mexican,  Specify:	Puerto Rican, etc.)		White, etc.				
003	ural',	d by	3 M Widowed 4 ☐ Divorce	d Year or D	Dates:						Mhite				
<u>1</u> 5	n 72 l	Completed	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most	of working	16b. Kind of Busin	ess/industry				
212	d with	omp	Elementary/Secondary (0-12) 12	College (	1-4or 5+)		emaker	,		Own Home	•				
g	al Hyg	Bec	17. Father's Name (First, Middle	, Last)				18. Mother	's Name (First, Middle,						
<u>yla</u>	Menti Menti arked	To.	Michael Peti			Τ			ia Serrete						
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan nent of Health and Mental Hygiene. sont: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other traumatic event, the Madical Extening rate by notified at		19a. Informant's Name/Relation						or Rural Route Number						
e,	1 and Healt tem 2	1.	Alfred A. St	ango / So	20b. P	lace of Dispo	osition (Name of		Bethany Bea	20c. Location - City					
OE .	ent of mi: # I		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State		matory`or other plac Heaven Cei		t. 2, 2006		Spring, MD				
alti	permit. Page Department of Importent: If eny Injury or once		21. Signatur of Fineral Service			22	2. Name and Addres	ss of Facility							
m	88 1 8 8		Francis J. Collins Funeral Home, Inc. 500 University Blvd., West, Silver Spr												
	Physician /Medical Examiner	23a. PaR1: Enter the disease, or complications that caused the disease or complications that caused the disease or condition resulting in death)  Due to (or as a copsequence at the mode of dying, such as cardiac or respirat. Where the mode of dying, such as cardia													
8760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	uerfice of):	b //	Yac	live						
9	tificate og phy as the	ledic		- G				1	W						
P.O. Box	The law requires that the death certific ete has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	Icome of pregnal birth 2 □ Fetal nanI at time of de lown	death 3[	Ectopic pregnancy Other (specify)	V	461356	23d. Date of Month	f delivery Day Year				
	w requires that been signed to should be deta	by	Part II. Other significant conditions and the conditions of the co	ions contributing to d	leath but not resu	ulting in the u	nderlying cause give	en in Part I.		_	te to the cause of death?  Probably 4 Vunknown				
Division of Vital Records,	ilcian: The law re certificete has be rector, page 2 sho	Completed	Hyp	ellense	r				24a. Was autor perfo	osy prior ormed/ deat	e autopsy findings available r to completion of cause of th? Yes 2 \sum No				
/ita	Physician: r this certifice ral director, I	Be	25. Was case referred to medic examiner?						of Death Check only	_ ~ `					
of/	Physi this c al dire	2	1 Yes 2 No 27. Manner of Death	- Indiana		ER/Outpatier		4 🗆 Nurs	sing Home 5 Resid		Specify)				
U <sub>O</sub>	ding I h. After funer	tlon	1 □Natural 5 □ Pend	ing (Mon	of Injury oth, Day Year)	28b. Time of Injury	Worl	Yes 2 0	27	how injury occurred					
/ISi	Atten r deat octor: by the	flca	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At ho	me, farm, str	reet, factory, office		28f. Location (		or Rural Route Number,				
á	s after sale or all Direction to	Certification:	4  Homicide	build	ing, etc. (Specify	" Hours	E		5 LAUS	a marine of the	Space 40				
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Atter this certificete ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certify (Check only one) Medica	t Examiner: On the b	e best of my know easis of examinat oner stated.	wledge, death tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the a occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)				
)		W	29b. Signature and tile of certific	er			29c. Licensi	a number	147	29d. Date signed (M	Ionth, Day, Year)				
	10		CALICC -	IARWOLL	se of death (Item	23a) (Type,	Print) Lockullil	Piker	Rocania	K) MB 200	356				
	Sta Registr		31. Date filed (Month, Day, Year)	2006	Registrar's Signat	ture for	Les .								

		1 - For State Registrar	State of Maryla	ind / Depa <i>Cei</i>	artment o	of Healtl of Dea	h and M th	fental Hy	giene ()	06	32723
		1. Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
Physicia /Medic	al	DOROTHY JANE SMI			45 Ob. To.		(D1)	Septemb		2006	6:20 P <sup>M</sup>
Examine	er	4a. Facility Name (If not institution, give s REEDERS MEMORIAL H				wn, or Locati BOONS]			4c. Count	y of Death WASHI	NGTON
Funeral Director		5. Social Security Number 6. Sex 229-26-0240	м 2\ДF 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Y Months D	ear If United	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da JULY 1	th Year) 0, 1925	Cour	elace (State or Foreign htry) IRGINIA
ryland		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ecation					1	0d. Inside City Limits
ith the Marylar or 28e-f ehow	Director	MARYLAND WASHIN  10e. Street and Number	GTON		10f. Zip Co		SBORO		10g. Citizen of	What Cour	1  Yes 2 □ No
3a o		141 SOUTH MAIN STR	FFT			21	713			U.S.	۸
ier death w iteme 23a	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent			ecify Yes or No Rican, etc.)	- 14. Ra	ce - Americ	an Indian,
d 21215-0636 Itied within 72 hours after death with the Maryland Hygiene. Hygiene. Then "naturel", or Items 23s or 28s-1 show not, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		lfYes, specify 1□Yes 2🛣			Rican, etc.)	Specii	ick, White, fy: WH	etc. HTE
5-06-3	eted	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual O	done durina n	nast of work	ina	16b. Kind of B		
21215-0636 d within 72 hours alt giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOTUSO 1 SUBSTIT	retired)		•		EDUCA	ATION
G a a b	Be	17. Father's Name (First, Middle, Last) LUTHER DAVIS					other's Name		Maiden Sumai	me)	
aryla should and Men marke	၉	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (St	treet and Nu	mber or Run	al Route Numbe	er, City or Town	, State, Zip	Code)
ore, ME ss 1 and 2 of Health a item 27 ie		MR. RONALD C. SMIT	H, SON	960	AFTON	PLAC	E, HAG	ERSTOWN	I, MARYI	AND	21740
altimore, mit. Pages 1 a pertment of Hea portant: if item y injury or othe		20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □ Re		. Place of Dispo cemetery, crei	sition (Name of	of		Date	20c. Location		own, State
Itim it. Pag rtment rtant: njury		4 Donation 5 Other (Specify)  21. Signature of Juneral Service License	H	OLLY ME			1	6/2006	CHARLOT	TESVI	LLE, VA
Baltimor		21. Signature of Burnellal Saving License	-		Name and A ST FUN		DOMETE:	606 OLI	NATION O. MARY	IAL PI	KE 21713
Physician		23a. Part Erner the disease, or complication heart failure. List only on immediate Cause (Final	e cause on each line.				as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
376( ate be nysicie he bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	aquenes of):			2	a'Man			<b>7</b>
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifici- this certificate has been signed by the attending phiral director, page 2 should be detached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregn Other (specif					ate of delive	Dry Day Year
ds, Puries that is signed be detailed	d by PI	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying caus	e given in Pa	art I.				ne cause of death? ably 4 <b>Uhrk</b> hown
Cord Iw requir	lete	Hopeney den	521					24a. Was	an 24b.	Were auto	psy findings available
on of Vital Reding Physician: The land, h. After this certificate has funeral director, page 2						-		autor perfo 1 ☐ Yes	rmed?	prior to cor death? 1  Yes	
/ita	Be	25. Was case referred to medical examiner?	oonitel:					h (Check only o			
Physical this call dir	ို	1 193 25140		☐ ER/Outpatier					dence 6 Ott		1)
Jing Ling After	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)		М	Injury at Work?	i	28d. Describe I	now injury occur	rred	
Divis	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, of	ffice		28f. Location (S City or Tox	Street and Numb vn, State)	ber or Rura	l Route Number,
	Medical	29a Cartifier 1 Gentlying Physical (Check only one) 2 Medical Examin	ician. To the best of my ker: On the basis of exami and manner stated.	n. wladge, death nation and/or in	r occurred at the vestigation, in	he time, date my opinion,	and place, death occurr	and due to the red at the time,	date and place,	anner ac et and due to	ated the cause(s)
To th withir To th comp	ž	29b. Signature and title of certifier				cense numb			29d. Date signe		
		) -cut m				ડ (૪ ડ	19		SEPT	30,	2006
15H-Z		30. Name and address of person who con Dr. Vasant Datta	340 Mill St	reet H		own ,Ma	ryland	21740	301-73	39-710	00
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1 .						

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrer	State of M	<b>laryla</b> nd	-	artment rtificate			and M		iene 0	106	32724
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith		3. Time of Death
	Physici /Medi		PAUL JEFFERY	SHUMAKER							Month SEPTEMB	ER 28	2006	1128 AM
	Examir		4a. Facility Name (If not institution,	-			4b. City,		Location o			4c. Cou	nty of Death	
			WASHINGTON COUN			and the State of the State	If Under		AGERS'		0.00		WASHI	
П	Funeral Director		5. Social Security Number 220-52-2091	6. Sex 7. A 1(X)M 2□ F	ige (In yrs. la 57	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day JUNE 14	, Year)	Cou	place (State or Foreign ntry) ST_VIRGINIA
			Usual Residence of Decedent								JONE 14	1242	/ WIE	SI VIRGINIA
	arylan ehow		10a. State 10b. County MARYLAND WASH	INGTON	10c. City	, Town or Lo	cation	ЦΛС	GERST	OT.INT				10d. Inside City Limits 1 X Yes 2 □ No
	vith the Maryla or 28a-f ehov	Director		INGION			101 7		TOTAL	OMIN		10- Cirina	-4 14/h4 C	
	within 72 hours after deeth with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar most be notified at	5	10e. Street and Number 235 SUMMIT AVEN	IIE			10f. Zip		21740			10g. Citizen		S.A.
	ne 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	S. 13.	Was Deced				cify Yes or No- Rican, etc.)	14. F	Race - Ameri	can Indian,
9	or Iter	Ξ	1 XNever Married 2 ☐ Marrie	Armed Forces ad 1 Tes 2 7 If Yes, Give			fYes, spec 1 ☐ Yes 2		n, Mexican Specify:	ī, Puerto F	Rican, etc.)		Black, White	, etc.
93	inel',	d by	3 Widowed 4 Divorced	Year or Dates	:							Spe	WH	ITE
5-	72 hours "naturel", edical Exe	Completed	15. Decedent (Specify only highes			(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	t of workin	ng	16b, Kind of	f Business/Ir	ndustry
12	withii ithen	E C	Elementary/Secondary (0-12)	College (1-4o	r 5+)		AINTI			RKER		MUNTO	TPAT,	GOVERNMENT
Þ	illed Hygid other	Be C	17. Father's Name (First, Middle, L	ast)							(First, Middle,			
/lar	should be nd Mental marked o	TO B	LESTER MILTON S	HUMAKER					MAR	Y LUI	FIELDA	SWEENE	ΣΥ	
Maryland 21215-0036	ges 1 end 2 should be filed within 72 hc t of Heelih and Mental Hygiene. If Itam 27 ie marked other then "natur or other treumatic event, the Medical		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	Route Numbe	r, City or Tov	wn, State, Zi	p Code)
e,	l end leelth im 27 her tr		DONALD G. SHUMA  20a. Method of Disposition	KER, BROTH		1150 ace of Dispo			ROAD.		ERSTOWN	MARY 20c. Locatio		21740
Baltimore,	nt of h	H	1 X Burial 2 ☐ Cremation		C6	metery, crei	natory or of	ther place			/2006		-	, MARYLAND
뜵	permit. Pag Depertment Important: I eny Injury o		4 Donation 5 Other (Sp 21. Signature of Funeral Service L		1100		2. Name an				2000	OIZIG	DDORO	, TEMCLIERIO
Ba	permit. Depentra Importa eny Inju		Hour M/	Ma Pau	L M. D	ean I	BAST I	UNE	RAL H	OME j	7606 OL: BOONSBO	RO, MA	ONAL RYLAN	0.21713
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each	ed the death line.	. Do not ent	er the mode	e of dying	, such as					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):								
	4	ē	Sequentially list conditions, if any, leading to initiocate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	e a consequ	enga of):							-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
oʻ	ate be executed hysicien and ihe burial-transit	Exa	resulting in death) Last		s a consequ	ience of):	, ,							
8760,	ate hys	dical	,	d			·							
P.O. Box 6	ne death certif the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pri Other (sp					_	Date of delive Month	very Day Year
	quires that the signed by and be detac	[۾	Part II. Other significant conditio	ns contributing to death	but not resu	ilting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	,		the cause of death?
Division of Vital Records,	The law requir ste has been si pege 2 should I	Completed		4 · · · ·							24a. Was a autop perfor 1 ☐ Yes	SV	prior to co death?	opsy findings available ompletion of cause of
/ita	ilcien: Th certificete rector, peç	Be	25. Was case referred to medical examiner?		02H-1					of Death	Check only or	ne)		
<u>ک</u>	shysic this co	၉	1 ☐ Yes 2 ☑ No	Hospital: 1- Inpa		ER/Outpatier			4 🗆 140		ne 5 Resid			fy)
n C	aling F	ioi	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		ay Year)	28b. Time o Injury	м 2	8c. Injury Work	at :? ∕es 2 🗀 I		8d. Describe h	ow injury occ	curred	
isi	Attending Physicien: r death. ector: After this certifice by the funeral director, p	ficat	2 Accident investig 3 Suicide 6 Could n 4 Homiside determi	ot be One Diese of I	niury - At ho	me, farm, sti					8f. Location (S	treet and Nu	ımbər or Rui	ral Route Number.
Ö	elor setter	Certification:	4 - Homicide determi	building,	etc. (Specify	)	,				City or Tow	m, State)		· ·
	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best examiner: On the basis and manner:	of examinat	wledge, deat ion and/or in	h occurred vestigation,	at the tim	e, date an inion, dea	id place, a	and due to the o	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	ro the Mithin Fo the	₩ W	29b. Signature and title of certifier	2				. License				29d. Date sig		
	. , , ,		Muchael	1. mus	am 1	no		04	1166	7		9	. 29.	06
3	4-4		30. Name and address of person  Michael	o completed cause of		23a) (Type,	Print)	ledi	cel (	lan	nus	ltase.	nstou	n MD
		ate rar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	ure								
	•		001 0 4	LUUU Ma	eru -	17. 11	naral							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental He

		1-For State Registrar Certific	eate of Death		g No. 200	C 2270
Physici Medical Exam		THEFT MILLOWY BUILDING SI.		2. Date of Death Month October 3,		Time by Deeth 1710 hrs
		4a. Facility Name (if not institution, give street and number) 2000 Earl Sullivan Drive	4b. City, Town, or Location of Dea Harwood	ath	4c. County of Death Anne Arundel	
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last bir 217-96-2436 1 M 2 F 41	thday) If Under 1 Year If Under 24H Months Days Hours M		h(MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State or "Washington, "D.C.
v any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
viaryland 28a-f show datonce.	ctor	Maryland Anne Arundel	Crownsville		g. Citizen of What Coun	1 Yes 2 X No
with the Marylard ns 23a or 28a-f she be notified at once	al Director	819 Oak Trail  11. Marital Status 12. Was Decedent Ever in U.S.	21032		USA	try?
r death	/ Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer  1 Yes 2 X No specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	
2 hours afte "natural", Examiner	ted by	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind o during most of working life, DO NOT use re	f work done	Specify: Wh:	ite
15-0036 Hiled within 72 hour Hygiene d other than "natu	Completed		aster Carpenter	,	Constru	ction
21215-0036 build be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Phillip Maurice Smith		ne (First, Middle, Micia K. (		
MD 21 ad 2 should lith and Me n 27 is ma aumatic ev	То		b. Mailing Address (Street and Number of 5 Boston Drive, Oce			Zip Code)
re, N s 1 and 2 f Health If item 2	-1	20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery, tory or other place)		20c. Location - City or 1	own, State
Baltimore, MD 2: permit Pages I and 2 should Department of Health and M Important: If item 27 is milijury or other traumatic e		4 Donation 5 Other Specify: Kala  21. Signature of Fuperal Service Licensee	s Crematory 10	-8-06	Edgewater	, MD
	ij	What Mala	22. Name and Address of Facility e 2973 Solomons Isl	and Rd. E	Edgewater, N	MD 21037
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
₹xaminer		Immediate Cause (Final disease or condition resulting in death)  Methadone and alcohome of the condition resulting in death)  Due to (or as a consequence of):	IOT THEOXICACTOR			Deatti
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ed	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and he burial - transi	Medical	X UNPENDED X AMENDED item#1 23a 2	27,28a-f,perME,g860, 10/2	)3/06 TT		
68760, certificate be e. dring physiciar se as the burial	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2	Fetal death 3 Ectopic pregr		23d Date of delivery  Month Da	y Year
ath o	ysician/	1 Yes 2 No 9 Unknown 9 Unknown			, and the second	y rear
ires that the signed by the lbe detached	by Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I		acco use contribute to the	
rds, Frequires				1 Yes		bly 4  Unknown  psy findings available
Records, The law require	Completed			autopsy perform 1 ✓ Yes 2	prior to con	mpletion of cause of
of Vital Recing Physician: The offer this certificate meral director, page	B	25. Was case referred to medical examiner?  1 Very 2 No. 1 Inpatient 2 ER/Out	26.Place of Death (Check utpatient 3 DOA Other, Nursi			
n of \ Iing Phy After th funeral	2 2 2 3	27. Manner of Death  1 Notice   28a Date of Injury (Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe ho	esidence 6 🗸 Other s w injury occurred	scene
Division optial or Attendin hours after death ineral Director: A filled in by the ft	Certification:	Pending Investigation Prod 10/3/2006 Fnd	1 8:30 am 1 Yes 2 X No	unknown 28f, Location (Str.	eet and Number or Rura	Route Number City
Div Hospital o 24 hours af Funeral D		4 Homicide determined (Specify) other sce		Harwood N	10 2000 Farl S	ullivan Dr.
To the Hos within 24 h To the Fur	edica	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated	ith occurred at the time, date and place, and overtigation, in my opinion, death occurred	d due to the cause( at the time, date an	s) and manner as started d place, and due to the	d. cause(s)
-	Ž	29b. Signature and title of certifier	29c License number O.C.M.E.		29d. Date signed (Month	n, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)			October 4, 2006 	
Sta	te	Zabiullah Ali, M.D. Assistant Medical Examiner 11  31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 Penn Street, Baltimore, MD 21	201		
Regist		OCT 1 6 2006	emach !	·		

	,		1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment <i>rtificate</i>	of H	ealth a Death	nd Me		giene Reg. No.	2006	327	126
	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Dea		Year	3. Time of	
	/Medic			Robert Shock	cley, Sr					October				Рм
	Examir	er	4a. Facility Name (If not institution, give	street and number)				Location of	f Death			County of De	ath	
	Funeval		40 Muddy Lane 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday	E1k		If Under 2	4 Hrs.	3. Date of Birt		Cecil	rthplace (State o	r Foreign
	Funeral Director			MM 2□F 71	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Day AN 6,	1935	Pe	nnsy1var	
	۵ 🌲		Usual Residence of Decedent  10a. State 10b. County	100	0: 7									
	fanyla ahov	ō		100	C. City, Town or Lo	ocation							10d. Inside Ci	•
	28a-f	Directo	Maryland Cecil  10e. Street and Number		E1kton	10f. Zip (	Code				10a Citi	zen of What C		-A-
	h with	O	40 Muddy Lane				921					nited	,	
	death	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			spanic Orig	in? (Spec	ify Yes or No- ican, etc.)		14. Race - Am	erican Indian,	
36	or it	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2			1 40110 111	icari, etc.)		Black, Wh	ite, etc.	
8	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show dical Examiner must be notified at	Completed by	3 ☐ Widowed 4 🎇 Divorced  15. Decedent's Edu	Year or Dates:		dent's Usual					165 16	W	hite	
5	n na n na	piet	(Specify only highest grad	e completed)	(Give	kind of work DO NOT use	done di retired)	uring most	of working	7	100. KII	nd of Busines	svindustry	
212	giene giene er the	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Fa	rmhand					F	arming		
pu	be file tal Hy d oth	To Be (	17. Father's Name (First, Middle, Last)							First, Middle,				
Zla	ould Men Parke	<sup>2</sup>	Robert C. C. Sh							11a Bo				
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Ty Mabel J. Davis/S	*						ark, D				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If them 27 is marked other than "natural; or items 23s or 28s-f ahow any njury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition		Ob. Place of Dispo			1.5	Da	te		cation - City o		
Ë	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	cometery, cres R.A. Ferris			, 0	ctobe 1, 20	er	Wes	st Ches	ster,	
alti	permit. Departmitimporta		21. Signature of Funeral Service Licens						1, 20	als, P		IIISYIV	шта	
<u> </u>	88 58	(3)	Doneed.	8. Hicks		13 W.	Stoc	kton	Stre	et, Ell	cton	, Mary	land 219	21
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.							est,		Approximate Interval Betw Onset and D	v <i>e</i> en
	/Medical		disease or condition resulting in death)	Due to (or as a cor	nsequence of):								2413	Ans
ŧ.	Examiner		Sequentially list conditions.	Due to (or as a cor	na of	PRO	SM	12 (	CUM	NO			8 40%	No
7	ed ist	ulue	cause. Enter Underlying											
<u>,</u>	execu n and al-tra	xau	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	cons	pa	- lin	WALR	9 11/2	15456	;	5 761	rus
8760,	Attending Physicien. The law requires that the death certificate be executed and adaily.  The law form this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Examiner	L,											
89	ing ph	Medi	IF FEMALE:											
Вох	that the death certific ed by the attending p detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pro 1☐Live birth 2☐	Fetal death 3[	Ectopic pre					2	3d. Date of de	,	ear
P.0.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tim <i>e</i> 9□ Unknown	of death 5	Other (spec	crfy)					World	Day	Ga1
o.	s that ned by a deta	ьу Р	Part II. Other significant conditions cor	tributing to death but not	t resulting in the u	nderlying cau	use giver	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause of de	ath?
Division of Vital Records,	w requires t been signe should be									1 0	9s 2[	]No 3□P	robably 4 🗆 U	nknown
900	law requas been 2 should	Completed								24a. Was a		24b. Were a	utopsy findings a	vailable
<u> </u>	The cate h	Con								perform	ned? ∕	death? 1 □ Ye	completion of ca 3 2□:No	1036 OI
Vita	tending Physicien.* The leath. tor: After this certificate his the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:			T Other			Check only or				
ō	Phys rthis ral dii	2	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time of			7 17013		d. Describe h			ecify)	
on	nding I tth. :: After e funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	м	c. Injury a Work?	es 2□N		a. Describe in	ow nijuly	occurred		
Vis	or Attenafer deati	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	eet, factory,	office		28	f. Location (Si City or Town	reet and	Number or F	ural Route Numb	oer,
٥	ital or A			li de la companya de										
	To the Hospital or At within 24 hours after of To the Funarel Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at estigation, in	the time n my opii	, date and nion, death	place, and occurred	d due to the cat the time, d	ause(s) a ate and	and manner a place, and du	s stated. e to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier			29c. I	License i	number		2	9d. Date	signed (Mon	th, Day, Year)	
)			I folmer his	C'		00	007	462	>	0	CTO	BEN	11.200	6
	3		30. Name and address of person who co											
	Sta		Rolando Ar Najera,	M.D. 138 (	Cathedra	1 Stre	et,	E1kto	on, M	lary1an	d 21	921		
	Registra		31. Date filed (Month, Day, Year) 0CT 16 201	16	N. A.	SALE								

State of Maryland / Department of Health and Mental Hygiene 32727 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 9 ay Stepler 2006 9:15рт м Howard Russell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3702 Clear Run Place Rohrersville Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day, Year) Feb 5, 1941 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F 182-32-2738 65 Director Pennsvlvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits rthan "natural", or items 23a or 28a-f eho the Medical Examiner must be notified at Washington Maryland| Rohrersville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Clear Run Place 21779 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.

7 Is marked other than 'traumatic event, the Me. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attornev Legal Profession 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tone of Health and Mental H tant: If Itam 27 le marked off jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Howard Russell Stepler Sr Marv Mildred McClain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Stepler, Wife 7981 Parkland Place, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Smithsburg Crematory Oct 11,2006 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License <sup>2</sup>Keenev<sup>ac</sup> Bastord P.A. Funeral Home 23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 East Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Death Year Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of the Colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of) attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death ed by the a 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Hypertension Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1 Tes 2 X No tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ٩ 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending efter death. I Director: Af 2 Accident investigation М 1 □ Yes 2 □ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours e To the Funeral [ 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) October 10. 10587 Jeorg ( 4.0. ( spice of NEXLICK COUNT 30. Name and address if person who completed cause of death (Item 23a) (Type, Print) Mitte Mission FORCE 2006 370 Then Aut 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 6 2006 Registrar

				State of Mar				-	•	
			For State Registrer	olato ol mai		rtificate of			2006	32728
		Ť	1. Decedent's Name (First, Middle, Last,					2. Date of Death		3. Time of Death
ı	Physici /Medic		WILLIAM	*	VENABLE			Month SEPTEMB	Day Year ER 27 2006	7:35 A M
j.	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Deati	
			19524 CRYSTAL RO	CK DRIVE #	12	GERMAN			MONTGOM	IERY
	Funeral		5. Social Security Number 6. Sec	3M 2□ E	In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
	Director		219-84-8024 112 Usual Residence of Decedent	23.	41 Yrs.			JUNE 14	L965 WASH	INGTON, DC
	lend W		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Mary 1 sh	ō	MD MONTGOMI	CRY	GERMANT	OWN				1XXYes 2 ☐ No
	death with the Marylend ims 23e or 28e-f show if must be partified at	Director	10e. Street and Number		ODIGINI	10f. Zip Code		100	. Citizen of What Co	untry?
	h with	o is	19524 CRYSTAL RO	CK DRIVE #	1.2	20874	/.		U.S.A.	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H		ecify Yes or No-	14. Race - Amer Black, White	
9	or its	正	1₺ Never Married 2☐ Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2√ No	Specify:	Thoun, oto.,		
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						ACK
5	filed within 72 hours after Hygiene. sther than "natural", or Ite snt, Ite Medical Evande.	Completed	15. Decedent's Edu (Specify onfy highest grad	cation completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ang 16	ib. Kind of Business/l	ndustry
12	within then then	m d	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		ISABLED	<i>o</i> ,		NONE	
<b>d</b>	filed Hygin Sther	ပိ	17. Father's Name (First, Middle, Last)		<u></u>	LOWDEED	18. Mother's Nam	e (First, Middle, Ma		
an	should be filed within 72 hours after death with the Marylen of Mental Hygiene marked other than "natural", or Itams 23e or 28e-1 show marked other than "natural", or Itams 15e rottling an imate svent, its Medical Exerciting master profiled at	To Be	WILLIAM VENABLE				CHARLOTT	E DRAFF	ΙN	
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Ty	pe, Print)					City or Town, State, Z	
	and 2 alth a 127 is or tra		Kisha Matthews SIS	STER	425	ATLANTIC	ST S.E. W	ASHINGTO	N,DC 20032	
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked any injury or other traumatic stans.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	сө)	Date 20	c. Location - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 Donation 5 Other (Specify)			Cemetery		7, 2006 W	ashington	,D.C.
alt	permit. Depenti Import any inj once.		21. Signature of Funeral Service Licens	90 )		2. Name and Addre	0.		NS FUNERA	
ш	E05 = 0		K. D. 19	-hall					R, MARYLAND	
Г			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not er	iter the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
24	Physician		Immediate Cause (Final disease or condition	_CARDIOMY	OPATHY					Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
		<u></u>	Sequentially list conditions,	Due to (or as a						
	rted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		PYELONEP	HRITIS				
Ć,	be executed icien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a d						
760,	0 % 0	cal		SEPSIS						
9	tificat ng phy as th	ledi	S-57-							
Вох	eath certifi attending	an/N	230. was decedent pregnant	3c. If yes, outcome of 1 Live birth 2 (		□Ectopic pregnancy	,		23d. Date of deli	•
<u>о</u>	The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin	_	Other (specify)	<u></u>		Month	Day Year
<u>P</u>	d by I	Phy	9 ☐ Unknown  Part II. Other significant conditions con	stabuting to death but	not roculting in the	undorhing anuae au	on in Dart I	22o Did toba	cco use contribute to	the sauce of death?
ds,	signed d be det	by	Tatti, other significant conditions con	anduling to death but i	not resulting in the	andenying cause giv	en in Fait.			bably 4 🕅 Unknown
Ö	w requir been si should	etec								-
3ec	hysician: The law his certificate has E I director, page 2 s	Completed						24a. Was an autopsy performe	prior to c death?	topsy findings available completion of cause of
_ E	n: Th ficete or, pa		25. Was case referred to medical					1 ☐ Yes 21	No 1 ☐ Yes	2 <b>X</b> No
₹	sicia cert lirecte	To Be	examiner?	fospital:	2 ER/Outpatie	int 3 DOA Oth	or	h Check only one	ce 6 □Other (Spec	.4.1
ō	0 ~ 0		27. Manner of Death	28a. Date of Injury	28b. Time			28d. Describe how		iny)
<u>o</u>	nding f ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injury		Yes 2 □No			
Division of Vital Records,		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru. State)	ral Route Number,
۵	itel or rs aft el Dii	Cer								13
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I		(Check only 2   Medical Exami	sicien: To the best of o	xamination and/or ii	th occurred at the tir	me, date and place,	and due to the cau	se(s) and manner as	stated. to the cause(s)
	To the h within 24 To the F complete	Medical	one) 29b. Signature and title of certifie	and manner state	d.	29c. Licens			. Date signed (Month	
1	2 1 × 100		- Duysu	TUNONIN	M.D.		40201			
^	2		20 Name and address of several			1	,000;	37	y ander	28, 2006
K	(5)		30. Name and address of person who conformation FARZAD ASSAR M.D.				RMANTOLIN	MADVIAND	2087/	
	Sta	te	31. Date filed (Month, Day, Year)	A Registraria	s Signaturo	- ungine s	MANT LAMIN	riak i LAND	20074	
	Registr	ar	SEP 2 9 2006	Blow	Is the	(E)				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland				ealth a Death	nd Me		gienę.	11116	32729	)	
			1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea Month	ith Day	Year	3. Time of Death	_	
	Physicia /Medic		Henry Fritz Vo	ollmer						Septemb			6 2:13 P M		
	Examin	2	4a. Facility Name (If not institution, give s			4b. City	, Town, or	Location of	Death	_		County of Dea			
			12319 Whitehall				owie					ince C	eorges		
	Funeral Director		340-20-1499	7. Age (In yrs. II	ast birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day July 26	Year) 19	C	thplace (State or Foreign ountry) linois		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits	_	
	f sho	ŏ	MD Prince G	eorge's	Bow.	ie							1 XYes 2 ☐ No		
	28a	Director	10e. Street and Number	corgo z			p Code				10g. Citiz	en of What C	ountry?		
	3a or	۵	12319 Whitehall I	Drive				20715			-	USA	•		
	ms 2	Funeral		12. Was Decedent Ever in U.	S. 13. \	Was Dec			in? (Spec	ify Yes or No- ican, etc.)	1	4. Race - Am		-	
9	after or its	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1√2 Yes 2 □ No	1				Puerto Hi	ican, etc.)		Black, Whi	te, etc.		
8	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1951 -	-53	1 🗀 10\$	2 <b>∑X</b> No	Specify:				Specify: Wh	ite		
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f show hadical Examiner must be notilied at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	kind of w	ork done d	furing most	of working	7	16b. Kin	d of Business	Andustry		
2	Athin ne ne ne ne ne ne ne ne ne ne ne ne ne	id I	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired		~·	-7'	at - t	C M			
2	led w lygier her ti	S	47 Fabrus Mind Middle ( - 1)	5+	Acade	emic	Pran						aryland	_	
Ē	be fi	Be	17. Father's Name (First, Middle, Last)							First, Middle,		Sumame)			
3	d Mer narke	2	Henry Vollmer	Trial	101-14-15		/2			Stockf			T. 0. / )		
Maryland	12 st h and 7 is n traun	6	19a. Informant's Name/Relationship (Typ			_				Route Numbe BOWie					
e,	1 and Heelt em 2 ther		Barbara U.Vollmer  20a. Method of Disposition	/ spouse	lace of Dispo			ll Dr	Da			ation - City or		_	
و	in the		1 ☐ Burial 2 【Cremation 3 ☐ Re	emoval from State	emetery, cren	natory or	other plac								
Baltimore,	it. Pe		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens							)/2006_			a, VA.	_	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, it's Madical Examinal must be notified at Once.	V 9	Chuan Fowell 6512 NW Crain Hwy. Bowie, MD. 20715												
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death re cause on each line.	. Do not ent	er the mo	de of dyin	g, such as c	ardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death		
}	Physician		Immediate Cause (Final disease or condition	Acute myoca	ardial	inf	arcti	on					immed.		
	/Medical Examiner		resulting in death)	Due to (or as a consequ											
	LXammer			Arterioscle		hea	rt di	sease					16 yrs.	_	
	bed ist	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ									27		
	and al-trar	xan	that initiated events c. resulting in death) Last	Diabetes I	Mellit	us				-			27 yrs.		
3760,	ate be executed hysicien and the burial-transit	caiE	L.												
687	ficate p phy: is the													_	
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnat							2	3d. Date of de	livery		
ă	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetat 4□Pregnant at time of de		JEctopic   Other (s	pecify)					Month	Day Year		
P.O.	t the by the tache	Physician/Med	9 □ Unknown	9□ Unknown										_	
Vital Records, F	The law requires that the death certifics sie hes been signed by the attending phage 2 should be detached for use as it	þ	Part II. Dther significant conditions con Renal failure		Ilting in the ur	nderlying	cause give	n in Part I.					o the cause of death?		
Ö	w require been si should b	lete	Amputation of	toes						24a. Was a	an	24b. Were a	utopsy findings available	_	
Re	The la	Completed					-			autop	med?	death?	completion of cause of 2 □ No		
ta	en: tifice tor, p	0	25. Was case referred to medical					26. Place	of Death (	1 ☐ Yes Check only or		1 1 16:	2 140	. —	
$\leq$	Physicism: this certifice ral director, p	To B	examiner? 1 ☐ Yes 21X No	ospital: 1   Inpatient 2   1	ER/Outpatien	t 3 🗆 D	OA Othe			e 5 🛣 Resid		□Other (Spe	ocify)		
0	g Ph ter th seral	=	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	at		d. Describe h			- 7.	-	
<u>.</u>	Attending in death. ector: After by the fune	atic	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 2.5, 7.2,	,,	М		res 2 □N	lo						
Division of	el or Atte s efter de il Directo id in by ti	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, facto	ry, office		28	If Location (S City or Tow		Number or R	ural Route Number,		
	To the Hospitel or Attending Physicism: The lav within 24 Universelter death.  If o the Funeral Director: Atter this certificate hes completely filled in by the funeral director, page 2	Medical (	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurre vestigatio	d at the tim	e, date and inion, death	place, an	d due to the c d at the time, c	ause(s) a late and p	and manner a place, and du	s stated. e to the cause(s)	_	
	To the I	ž	29b. Signature and title of certifier	2		1	c. License		2	Z	29d. Date	signed (Mon	th, Day, Year)		
	166 . DA		Dru 06	Ra che.			DI	3337	1	Merchanism	9	125/0	6		
			30. Name and address of person who con	mpleted cause of death (Item	23а) (Туре,	Print)						, , ,		_	
_	July		T. Chanchien, M.			Dr.	Ber	wyn H	eight	ts, MD.	20	740			
77	Sta Registr		SEP 2 7 2006	32. Registrar's Signat	ture										

Please Type or Print in Black Indelible Ink

06-07113	Please Type of Print in Black indelible link
Tyrone Carlos Venable	State of Maryland / Department of Health and Mental Hygiene
4 5 04-4-	Contificate of Dooth

rone Carlos ve	1-	- For State Certificate of	Death	Reg. No	2006 3273
Physicia edical Examin	n/ 1	Tyrone Carlos Venable		2. Date of Death  Month Day September 20,	Year 1147 hrs
Edical Exam		4a. Facility Name (if not institution, give street and number)  8416 11th Avenue	b. City, Town, or Location of Death Silver Spring	4	c. County of Death Montgomery
Funeral Director		5. Social Security Number 2 2 8 - 1 1 - 1 9 4 4 6. Sex 1 XM 2 F 4 5 Yrs.		8. Date of Birth (MN Feb. 2, 1	961 Foreign Wash.D.C.
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show any transatic event, the Medical Examiner must be notified at once.	ral Director	1 Never Married 2 Married Armed Forces? If Yes 2 No	Spring  10f. Zip Code 20903  s Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto I	U ecify Yes or No-	itizen of What Country? S.A.  14. Race - American Indian, Black, White, etc. Specify:  Black
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Irant: If item 27 is marked other than "matural", or other transmatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Leg  17. Father's Name (First, Middle, Last)	Yes 2 XNo specify:  It's Usual Occupation (Give kind of wost of working life. DO NOT use retire al Assistant  18.Mother's Name  Mary	ed) (First, Middle, Maide	. Kind of Business/Industry Private
MD 2121; d 2 should be fill th and Mental F n 27 is marked numatic event,	To Be		Address (Street and Number or R 10 Cherokee S	ural Route Number,	City or Town, State, Zip Code) 20 / 40 2 College Park Md
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other transmatic event, the Med		1 XBurial 2 Cremation 3 Removal from State Ga T11ee  4 Donation 5 Other Specify:  21. Signature of Funeral Service Liceosee	Name and Address of Facility Wa Robinson Funer	sh nome	C. Location - City or Town, State Saxe, Va.  Canal Can
Physician Medical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the filtere. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause cause. Enter Underlying Cause cause.		r respiratory arrest, s	Shock, or heart Approximate Interval Between Onset and Death
60, cate be executed physician and he burial - transit	ical Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED			
Box 68760, s death certificate be the attending physici ed for use as the buri	Physician/Medical	past 12 months?  1 Yes 2 No 9 Unknown  Unknown  Discretely pregnant at time of death 5 0	etal death 3 Ectopic pregnather (Specify)	ancy	23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		2 No 3 Probably 4 Vunknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Ves 2 No
tal Restant Tilant Til	Be C	25. Was case referred to medical examiner? Hospital: 4 Inception 2 FR/Outpatien	26.Place of Death (Check	-	sidence 6 🗸 Other: Scene
n of Vil Inding Physic there: After this	ion: To	1 V Yes 2 No Impate 2 Errosspand	•	28d. Describe how	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, City e)
o the Hospi Ithin 24 hou o the Funce	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigation and manner stated.	urred at the time, date and place, an ation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s)
<b>1</b> ≥ 1 8	₩ We	29b Signature and title of certifier  Pattern Or on Car - Polled us	O.C.M.E.	l l	9d. Date signed (Month, Day, Year)  September 21, 2006
CR B		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimo	re, MD 21201	
S Regis	tate stra		W		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2006

32731

		-	For State Of Ma		tificate of Death		ai mygienę Reg. No	_	32/31
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)			M	ate of Death onth Da	y Year	3. Time of Death
H	/Medic	al .	John William Vogt  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		tember 2	28, 2006	
	Examin	er	9721 Wyman Way		Upper Marlbor		P	rince G	eorge¹s
П	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year				thplace (State or Foreign nuntry) nsylvania
	Director		190-16-3547	82 Yrs.		Ja	n. 23, 1	924   Pen	nsylvania
	yland III		10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Prince George's	Upper Mar	lboro				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show r.mail be notified at	Funeral	9721 Wyman Way  11. Marital Status  12. Was Decedent f	Ever in U.S. 13. V	20772	igin? (Specify )	es or No-	USA 14. Race - Ame	erican Indian,
	ifter d		Armed Forces?  1 Never Married 2 Married 1 Xes 2 N	lo	Vas Decedent of Hispanic Ori f Yes, specify Cuban, Mexicar		, etc.)	Black, Whit	e, etc.
2	ours a	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Yes 2 🕅 No Specify:				White 
0500-C12	be filed within 72 hours after death with the Marylan Hygiene. d other then "natural", or Items 23s or 28s-f show event, the Macilcal Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b. K	and of Business	/Industry
717	within	omp	Elementary/Secondary (0-12) College (1-4or 5	+)	. Colonel		US	AF	
פ	be filed tal Hygi d other event, t	Bec	17. Father's Name (First, Middle, Last)		18. Mothe		t, Middle, Maider	Sumame)	
Maryland		2	John Joseph Vogt			ose Wei			
Z Z	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Mark L. Vogt - Son	1	Bald Eagle Sc				
_	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition	20b. Place of Dispo- cemetery, cren		Date		ocation - City or	
Ë	8° = 5		1 🛱 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donațion 5 □ Other (Specify)	Arlington	n Nat'l Cem. 1	11-16-2	006 Ar1	ington,	VA
Baltimore,	permit. Pag Department Important: eny injury o		21. Signatule of Fune At Service Ligens e	100000	Name and Address of Facili	J.	035 01d		
	40204		23a. Part1 Enter the disease, or complications that caused shock, or heart lailure. List only one cause on each lir		untt Funeral F er the mode of dying, such as			waldort	Approximate
	Physician		shock, or heart lailure. List only one cause on each lir Immediate Cause (Final disease or condition	1	in tunos.				Interval Between Onset and Death
	/Medical		resulting in death)	a consequence of):	on cano				
E	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	3 0011004251100 01/1					
oʻ	execu en and rial-tra	Exa		a consequence of):					
68760,	icate be executed physicien and s the burial-transit	edicai	đ.						
×	leath certifici attending ph for use as t	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of de	livery
. Box	death certificate be executed e attending physicien and od for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
Р. О.	res that the de signed by the a be detached f	Phys	9 Unknown			. 1.	Distribution		- the assess of death 2
		Ď	Part II. Other significant conditions contributing to death b	. 1 .	nderfying cause given in Part I	l	23e. Dig tobacco 1 ☐ Yes 2		o the cause of death?
Ö	w requ	letec		9 11-2	craj		24a. Was an	24b. Were a	utopsy findings available
Vital Records,	Physician: The lav this certificete has al director, page 2	Completed					autopsy performed? ☐ Yes 2 🗷 No	prior to death?	completion of cause of s 2□ No
<u>ra</u>		BeC	25. Was case referred to medical examiner?		26. Place	e of Death (Che		,	
	hysic this ce	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien			5X Residence		ecify)
uc	ding P. h. After funera	tlon:	27. Manner of Death  1 Natural  28a. Date of Inju (Month, Da)	ry 28b. Time of Year) Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐		Describe how inju	ary occurred	
Division of	Hospitel or Attending Physician: 24 hours effer death. Funeral Director: Affer this certific tely filled in by the funeral director.	Certification:	2 Could not be	ury - At home, larm, str		28I. L	ocation (Street a		ural Route Number,
ā	rs efte rs efte ei Dir	Cert	a Homeda	s. (Spacity)			ony or rown, stat		
	To the Hospital within 24 hours e To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	examination and/or in	n occurred at the time, date ar vestigation, in my opinion, dea	nd place, and d ath occurred at	ue to the cause(s the time, date an	s) and manner a d place, and du	s stated. e to the cause(s)
	To the I	Me	29b. Signature and title of certifier		29c. License number		29d. Da	ate signed (Mon	th, Day, Year)
•			Mais allelts	me -	1)2374	13	9	129/04	/
1	NBINEL		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	1	Topph	01+ 200	170 31	982-9803
	Sta			ar's Signature	1	411111111111111111111111111111111111111	C au	20 001	
ŧ	Registr	ar	OCT 0 2 2006 Deep	w & A	Market J				

State of Maryland / Department of Health and Mental Hygiene 2006 32732 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 9:10A SEPTEMBER 25, 2006 KATHERINE ELIZABETH WESTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** CLINTON PRINCE GEORGES BRADFORD OAKS NURSING & REHAB 8. Date of Birth (Month, Day, Year) FEB 20 1 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex **Funeral** Days WASHINGTON, Months Hours 1 M XZX F Yrs. 250 03 2432 85 1921 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f ahow other traumatic avent. The Madical Examiner must be notified at XXYes 2 ☐ No Director MD PRINCE GEORGES CLINTON 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with ō Itams 23a 7520 SURRATTS ROAD 20735 UNITED STATES be filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes ŽXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK XX Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8TH HOUSEWIFE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F JOHN McPHERSON WINNIE DAVIS Pages 1 and 2 should nent of Health and Men 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 LILLIAN G. WILLIAMS / DAUGHTER 607 49TH PLACE, NE WASHINGTON, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 09/30/2006 LANDOVER, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. Min 4308 SUITLAND ROAD SUITLAND, MD Approximate Interval Between Onset and Death 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician EMPHY SEMA** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, have leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consiguence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year jo in the past 12 months? 1 ☐ Yes XX No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes A21 No 2 No 1 TYes of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2XXNo Hospital: Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes 2 □ No death. after death 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide hours Funaral XX Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier letely (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D52741 SEPTEMBER 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINE J. CARNE 11701 LIVINGSTON RD. FORT WASHINGTON, MD 20744 . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 9 2006

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3.10 PM 23 2006 WHITE Seplembe ANNIË /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ellicott City Ellicott City Health & Rehab. Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Yrs. Director 578-30-6449 May 5, 1927 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in than "natural", or Items 23e or 28e-f show the Medical Exaction must be notified at 1 XYes 2 No Maryland | Prince George's Bowie Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Arbor Park Place 20721 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William May Poly Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09 Department of Health a Important: If item 27 is any injury or other tre once. Katie Thompson/Daughter 905 Arbor Park Place, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other Page) k 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Maryland National Mem. 9/29/2006 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Infected De Cubitus Immediate Cause (Final disease or condition resulting in death) Physician /Medical Atheroscientia Cardwascolo Discase **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine inheral Vascular Difease physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Renal Differe Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has b irector, page 2 st 24a. Was an 2 No 1 ☐ Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier D 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back RIVEL Neck Road Baltimery Mayladur

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygien 2006 32734 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** WILLIE MAE WALKER SEPT 2006 1:50 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3800 ENFIELD CHASE COURT # 312 BOWIE PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 79 Director 453-48-8074 AUGUST 1 1927 TEXAS Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No MDPRINCE GEORGE'S BOWIE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3800 ENFIELD CHASE COURT # 312 20720 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) HOUSE WIFE PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fift
Department of Heelth and Mental Hy
Important: If Item 27 is marked oth
any liqury or other traumatic event 17. Father's Name (First, Middle, Last) Be EMMETT ROBERTSON MILDRED MCCALLAN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12204 HURDLEFORD CT. BOWIE, MARYLAND EMMETT R. ROBERTS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 10/11/2006 ARLINGTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HEPATIC FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner HEPATOCELLULAR CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐ Pregnant at fime of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use confribute to the cause of death? Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No this certificate has or Attending Physician: after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other 4 Nursing Home SXXResidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury af Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 XNatural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pface of fnjury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel I 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confifigure 29d. Date signed (Month, Day, Year) Sept 26, 2006 11386 - HI 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANYA WROBLEDSLI M.D. 6900 GEORGIA AVENUE N. W. WASHINGTON, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 9 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieney 32735 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician 7:30 P M Wilson September 23, 2006 Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Larkin-Chase Nursing Facility Bowie, Maryland if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗶 F 577-34-2862 102 Director Oct 28, 1903 Odessa, Georgia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel; or items 23a or 28a-f ehov It e Medical Examiner must be notified at Director Maryland Prince Georges 1X Yes 2 No Bowie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 15005 Health Center Drive 20716 United States Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ent of Heelth and Mental tygiene. Interfited Tis marked other than "naturel; or ite iny or other treumatic event, the Medical Empiries iny or other treumatic event, the Medical Empiries 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lovenia Florence ပ Alexander Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth gitem 27 is other tre 7909 Polk Street, Glenarden, Maryland 20706 Marvin F. Wilson 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State artment of h artant: if its njury or of 4 ☐ Donation 5 ☐ Other (Specify) 9/27/2006 Landover, Maryland Harmony Mem. Park permit.
Depertuit
Importa 21. Signature Funeral Service Licensee 22. Na Pope dereteral Homes, P.A. Laru 5538 Marlboro Pike, Forestville, MD 20747 momen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Heart Disperse **Physician** /Medical Due to (or as a consequence of) Examiner ementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit phocos Due to (or as a co equence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death signed by the e Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has t irector, page 2 s 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after to the Funeral Dire 4 | Homicide To the Hospital 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur title of certifier 29d. Date signed (Month, Day, Year) 29c. License number of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 2 7 2006 Registrar

			For State	State of Mary		epartment of F Certificate of		lental Hy	giene		
	3		Registrar  1. Decedent's Name (First, Middle, Last)			Der till Cate Of	Dealli	2. Date of De	ath 2	106	3 inte of beath ()
€	Physicia	44	_	A. Washin	gton			Month Sept.29	,2006	Year	5:05a. M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Death			y of Death	
		6	Holy Cross Hospi		um la at hinth	Silver		8. Date of Bir	Monte		
	Funeral Director		5. Social Security Number 6. Sex 150 09 1902	M 2□F	yrs. last birtho 91 <sup>Yr</sup>	Months Dave	Hours Min.	(Month, Da	v. Year)	9. Birting	place (State or Foreign ntry) N.J.
	D		Usual Residence of Decedent	110				1 0 7 2 0 7 2			
	show show	P	10a. State 10b. County		c. City, Town o						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	rect	MD. Montgome  10e. Street and Number	ry	Silver	Spring 10f. Zip Code			10g. Citizen of	What Cou	X
	th with 23a or 1st be	Funeral Director	321 University Blv	d.W #241		2	0901		υ	JSA	
	tems term	uner	Tr. Mariar States	12. Was Decedent Ever Armed Forces?	r in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	lispanic Origin? (Span, Mexican, Puerto	ecity Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americ ack, White,	
36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specia	fy: Bla	ıck
90	'2 hou natura ical E		15. Decedent's Educ (Specify only highest grade	cation	16a. D	ecedent's Usual Occup	pation	ina	16b. Kind of E	Business/In	dustry
21215-0036	Ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done ife. DO NOT use retired		, rg	Govern	ment	
	filed w Hygien Sther tl ent, th	S	12years 17. Father's Name (First, Middle, Last)			ectrical T		e (First, Middle,	. Maiden Surna	me)	
au	ould be f Mental I arked of atic eve	To Be	· · · · · · · · · · · · · · · · · · ·	Robert Was	shingto	n	18. Mother's Name Rosa B	elle Ja	ckson	,	
Maryland	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 Is marked other t any injury or other traumatic event, the		19a. Informant's Name/Relationship (Typ Donna R. Washingto			Mailing Address (Street 7 Crest Ave				, State, Zip	code)
altimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R		20b. Place of D cemetery,	Disposition (Name of crematory or other place	ce) ;	Date	20c. Location	- City or To	own, State
E E	tment tant: I		4 □ Donation 5 □ Other (Specify)		Mt. 01	ivet Cem. 22. Name and Addre		/2006	Washin		
Bai	permit Depar Impor any In		21. Signature of Funeral Service License	Juan Sm	ull		h ST.,N.E				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the re cause on each line.	death. Do no	t enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	CARDIOM	-						
	Examiner			CORONA F		RY DISEASE					
	D #	ner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying	Due to (or as a co	risaquence of)						
	ecuter and -trans	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
68760,	cate be executed physician and the burial-transit	dicalE				TORY FAILU	RE				
			IF FEMALE:	3c. If yes, outcome pf p	regnancy				22d D	ate of deliv	on.
O. Bo	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □ Ectopic pregnancy 5 □ Other (specify) □	y			lonth	Day Year
σ,	that the phase the phase shades	by Ph	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the	he underlying cause giv	en in Part I.	23e. Did t	obacco use con	ntribute to t	the cause of death?
rds	equires en sigi ould be							10	Yes 2 □ No	3☐ Pro	bably 4 Unknown
Division or Vital Records, P.O. Box	e lav has je 2	Completed						24a. Was auto perfo		. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
/ita	certificate ector, pag	Be C	25. Was case referred to medical examiner?			la	26. Place of Deat				
or o	Physle this c	유	1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outp		4 Li Nursing Ho		dence 6 □Ot		fy)
On	iding Ph th. : After th funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		ury Wor	yan k? Yes 2 □ No	26d. Describe	now injury occu	rreu	
VISI	Hospital or Attend 44 hours after death Funeral Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - building, etc. (5	At home, farm Specify)	n, street, factory, office		28f. Location (	Street and Num wn, State)	ber or Run	al Route Number,
Ö	nital on Jus afte rai Di										
	To the Hospital or within 24 hours after To the Funeral Dir. Completely filled in b.	Medical		sician: To the best of m ner: On the basis of exa and manner stated	amination and/	or investigation, in my	opinion, death occur	red at the time,	date and place	, and due t	to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier			29c. Licens	55148		29d. Date signe 9/29/200		Day, Year)
1	(10)		30. Name and address of person ho con DELROY PETER ANGL			ype, Print) LENN RD. S]	LVER SPR	ING,MD.	20910		
Ì	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	Sperke					
	Registi	al	OCT 0 3 20	JUS Closus	W _ W	Marie					

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygierie 0 0 6

32738 Certificate of Death Reg. No.

2. Date of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death 25,2006 Year **Physician** SEPT. ANNA WILSON 5:05 A.M. BERNICE /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MD. MONTGOMERY WASHINGTON ADVENTIST 3600 CARROLL AVENUE Hours Min. 8. Date of Birth Month, Day, Year 15 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months Days Yrs. 226-20-0970 91 VIRGINIA Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "netural", or itams 23a or 28s-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or Itams 23a or 28a-1 show treumstic avent, the Medical Examiner must be notified at 1X Yes 2 □ No MARYLAND PRINCE GEORGE MT.RAINER Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 PERRY STREET 20712 U.S.A.Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK δ 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE HOME MAKER 8

17. Father's Name (First, Middle, Lest) JOHN WOOD

18. Mother's Name (First, Middle, Maiden Sumame) EVA DAVENPORT WOOD

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNICE A. HUDNALL (DAUGHTER) 3601 PERRY STREET MT. RAINER MARYLAND 20712

20b. Place of Disposition (Neme of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

BEULAH BAPTIST CHURCH10/2/06LIVELY VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility BERRY O • WADDY

6784 MARYBALL ROAD LANCASTER VA. 22503 Wi CC0233

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failule. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

RESPIRATORY FAILURE ACUTE

Due to (or as a consequence of):

PNEUMONIA

SEPSI/S

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CARDIAC ARRHYTHMIA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 X No

27. Manner of Death

1 Netural

2 Accident

3 🗌 Suicide

4 - Homicide

investigation

5 Pending

6 Could not be determined

Hospital: 1, Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c.

1 Tes

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

11052855

29d. Date signed (Month, Day, Year)

9/26/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3600 CARROLL AVENUE YAKOMA PARK MARYLAND CHANDRA KORAPATI  $M \cdot D \cdot$ 

31. Date filed (Month, Dey, Year) State Registrar

OCT 0 5 2006



Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be file.
Department of Health and Mental Hygi
Important: If Itam 27 le marked other any injury or other treum-41000ce.

Be

ပ

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medicai

Director: /

To the Hospital within 24 hours To the Funerel

**Physician** /Medical Examiner

the attending physician and hed for use as the bunel-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the s should be deteched hes this i or Attanding Fafter death.

				Please	Type or Prin				•	_	
			For State Registrar		State of Ma		partment of l ertificate of			eg. No.	16 32739
	Physicia /Medic		Decedent's Name     EMMA	(First, Middle, La	WOHNER				2. Date of Deat Month SEPTEMBE	Day	Year 3:51 A M
	Examin	- 1	4a. Facility Name (If UNION	not institution, giv HOSPITAI	re street and number) LS		ELKTO			4c. County CECI	
	Funeral Director		5. Social Security No. 226–28–69  Usual Residence of	99	Sex 7. Ag 1 □ M 2 💢 F	e (In yrs. last birthd 84 Yrs	Months Davs		8. Date of Birth (Month, Day, AUG 11,	Year)	9. Birthplace (State or Foreign Country) BLUEFIELD, WV
Maryland	fiedat	tor	10a. State  MD	10b. County  CECIL		10c. City, Town of ELKTO					10d. Inside City Limits 1 ☐ Yes 2X No
with the	3a or 28a at be notifi	Funeral Director	10e. Street and Num				10f. Zip Code 2192	L	1	0g. Citizen of V	Vhat Country?
d 21215-0036 filed with the Maryland	ti of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at	þ	11. Marital Status 1 □ Never Marrie 3 ☒ Widowed		12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cut	oan, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Blac	e - American Indian, ck, White, etc. ··· WHITE
21215-0036	an "natur Mazical	Completed	(Speci	15. Decedent's E fy only highest gr		(G	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of world	king	16b. Kind of Bu	usiness/Industry
nd 21	and Mental Hygiene. Is marked other than aumatic event, ITEM	Be Com	12 17. Father's Name (				HOMEMAKEI		ne (First Middle, M ANN I E IMER	OWN ] Maiden Sumam	
arylandshould be	Menta arked atic ev	To B	LUTHER		HUGHES						
2 5	Health and em 27 is m sthar traum		19a. Informant's Na KENNETH		(Type, Print) OHNER/ SON	1	ailing Address <i>(Stree</i> 069 IRISH)		NORTH EAS		
imore	nent of He ant: if item ury or oth				Removal from State	cemetery,	sposition (Name of crematory or other plants)  NTS CEMETE	ace)			City or Town, State  GTON, DE
Balt	Department Important: if any injury o		21. Signature of Fu	feral service lice	Merger		SPICER-MUL LOUG N DUP				.9720
	hysician		Immediate Cause ( disease or condition	Final	nplic tion at caused y our cau e on each li	the death. Do not ne.		ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death Tunk yung
	Medical xaminer	_	resulting in death)  Sequentially list cor	nditions.	Due to (or as	a consequence of):		ulmonar	y Disaeus	1e	years
60,	sian and urial-transit	Examlner	Sequentially list con it any, leading to im- cause. Enter Unde- Cause (Disease or that initiated events resulting in death) L		с	a consequence of):		-		<del></del>	
68760,	physician the buria			·	d						
ecords, P.O. Box 687	ed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 Mary 9 ☐ Unknown	months?	23c. If yes, outcome 1	2 Fetal death	3 ⊟Ectopic pregnand 5 □ Other (specify) _	су		23d. Dat Moi	e of delivery nth Day Year
rds, P	n signed b	by	, a	icant conditions	contributing to death b	out not resulting in th	e underlying cause g	iven in Part I.			ribute to the cause of death?  3  Probably 4 Unknown
of Vital Records,	£ 0	Completed							24a. Was a autops perform	ned? p	Nere autopsy findings available orior to completion of cause of death?  ☐ Yes 2 ☐ No
/ital	certificate rector, pag	Be C	25. Was case referr	red to medical					th (Check only on	e)	
of Vita	r this certifice	7	1 ☐ Yes 2 ☑		Hospital: 1 Inpatie	1 1		ther: 4 Nursing H	ome 5 Reside		

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

5 Pending investigation (Month, Day Year) Work? 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 9.29.2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Sachdes MD 118 North St Suite 38

31. Date filed (Month, Day, Year)

OCT 0 3 2006

Stewn St April

OCT 0 3 2006

MD 2/92/ Eleton

State Registrar

Medical Certification

29b. Signature and title of Cortifier

Please Type or Print in Black Indelible Ink

abtom Woldesel	1	- For State	ate of Maryla	-	partment e <i>rtificate</i>			l Menta	al Hyg		eg. No.	20	06	32741
Physician		tegistrar 1. Decedent's Name (First, Midd	le,Last)						2	Date of Dea	ith			Time of Death
ledical Examine	er	Habtom Woldes		umbor)	_	Lak	b. City, Town, or I	ocation of	Death	Month October 8		Year County of		0023 hrs
<i>)</i>		19931 Sweetgum Circ	_	illiber)		1-4	Germantow		Death			ontgome		
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday	y)	If Under 1 Year	If Under		8. Date of Bi	rth (MM/D			ice (State or
Director		279-02-5448	1 X M 2 F	47		Yrs.	Months Days	Hours	Min.	May 18	3, 19	59	Foreign Country	Ethiopia
>		Usual Residence of Decedent		1100 0	ity, Town or L	anatio		<u> </u>					100	d Inside City Limits
ow an		10a. State 10b. County MD Mont 9	gomery		rmanto		n1							Yes 2 X No
Aaryland 28a-f show any 1 at once.	힑	10e. Street and Number				WII	10f. Zip Code			1	l0g Citize	en of Wha		
th the Maryland 23a or 28a-f sho	Director	19331 Sweetgu	m Circle,	#14			20874				Unit	ed S	tates	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Dec	edent Ever in	1 U.S. 13		Decedent of His				D- 1	14. Race - White,		Indian, Black,
death or ite	Funeral		arried Armed F	2 X No					rueno K	ican, etc.)				
rs afte	⋧ -	3 Widowed 4 Div	vorced If Yes, Give Yea or Dates:		1 16a Dec		Yes 2 X No		nd of wo	rk done		Specify: B		strv
2 hou:	٦ ا يو	Elementary/Secondary (0-12)					st of working life.							,
1215-0036 d be filed within 72 hours after fental Hygiene. sarked other than "natural" event, the Medical Examine	ompleted		2		Tax	ica	ab Drive	r			Tax	cicab	Serv	rice
21215-0036 Juld be filed within 7 Mental Hygiene. The event, the Medica	ပေ	17. Father's Name (First, Middle		-	•				,	First, Middle,		Surname)		
d be f fental narked event,	8	Shefraw Wolde  19a Informant's Name/Relations			19h M	ailing	Address (Stree	2		Weldu		y or Town	State 7in	Code)
MD 2 shoullth and N 27 is n aumatic	٥	Lili Haile /		iece	1.0		B Brandy							
e, N L and 2 Health item 2		20a Method of Disposition		20		sposit	tion (Name of cen			Date		ocation - C		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranumatic event, the Medical injury or other tranumatic event, the Medical control of the Medical cont		1 X Burial 2 Cremation 4 Donation 5 Other S		om State G	ate_of	***	Cemete	<b></b>	10/1	2/2006	Si	lver	Spri	ng, MD
Baltimo permit Page Department of Important: injury or off	T	21. Signature of Funeral Service				22 Na	ame and Address	of Facility	narv	Servi	ce.	P. A.		
	4	23a. Part I. Enter the disease, or		M009	956	9:	33 Gist	Av. L	L. S	ilver	Spri	ng.	MD 20	910 pproximate Interval
Physician / Medical		failure. List only one cause	e on each line.					such as cal	I GIAC OI I	respiratory ar	1631, 31100	or, or near	E	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Narcot			ILOX	ICaltion						-	
Marie and Park		Sequentially list conditions,	b		0								_	
	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	a consequenc	e of):								-	
ed nsit	Examin	events resulting in death) Last	Due to (or as a	consequenc	ce of):									
f0, e be executed ysician and burial - transit	edical	UNPENDED	AMENDED	#10	III 00.	. 07	7 20- 5 -	MC	-060	12/5/00				
60, ate be e ohysicia ne buria		IF FEMALE:	23c. If yes,	#19a pe outcome of p		1,2/	,28a-f, pe	enue, g	3802,	12/5/00		. Date of d	elivery	
687 certific ading p	jan/	23b. Was decedent pregnant in t past 12 months?	Live	oirth nant at time o	2	_	al death 3	Ectopic	pregnan	су		Month	Day	Year
Box 6876C re death certificate the attending phys	Physician/M	1 Yes 2 No 9 Ur	nknown 9 Unkn		ideath 5	Oth	er (Specify)							
P.O. E es that the digned by the detached		Part II. Other significant condi	tions contributing t	o death but n	ot resulting in	the ur	nderlying cause g	iven in Par	t I.					cause of death?
S, P.C	ed by									1Ye				√ 4 <b>V</b> Unknown
ords, aw requir	Completed									24a. Was		pri		sy findings available pletion of cause of
tal Recol	틹									1 🗸 Yes	2 No		✓ Yes	2 No
tal ician: certif	Be	25. Was case referred to medica examiner?	Al Japanitali	Inpatient 2	ER/Outpa	tiont		of Death (		nly one) Home 5	Booder	nce 6 🗸	Othor: Co	
n of Vi Jing Physi After this funeral dir	위	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Tim			ry at Work?		28d. Describe	-			
ion c tending eath or: Af the fun	謞		nding Fnd 10	h, Day,Year) D/8/2006	Fnd 1	12 <b>:</b> C	01 am 1 🗆 `	res 2 X	No 1	unknown				
Division of Vital Records, tat or Attending Physician: The law requirers after death  al Director: After this certificate has been so led in by the funeral director, page 2 should be	<u></u>	3 Suicide 6 X Cou	ald not be	ce of Injury - A		_	t, factory, office b	uilding, etc	2	28f. Location or Town.	(Street ar	nd Number	or Rural F	Route Number, City III Circle
Divis	Certification:	4 Homicide	ermined (Specify	found	l at resi	iden	ice		ļ	Germanto	wn, N	10° 3'		
		Chick only	Physician: To the be aminer: On the basis	-										use(s)
To the within To the comple	Medical	29b. Signature and title of certif	and manner	stated.			29c. Licens	e number			29d. E	ate signed	(Month,	Day, Year)
		( ande	40	Q 0a	20		O.C.	M.E.			Octo	ber 8, 2	2006	
	ŀ	30 Name and address of perso									1			
			ssistant Medical	-			Street, Baltim	ore, MD	21201					
Sta Registi	_	31. Date filed (Month, Day, Year	1 2006 32.	egistrar's Sig	nature	100	MED							

			1 - For State Registrar	State of Mary		artment of H		, ,	ene 2006	32741
	Physici		1. Decedent's Name (First, Middle, L		DODYAR	20		2. Date of Death Month	Day Year	3. Time of Death 6 10:15 Am
	/Medio Examin		4a. Facility Name (If not institution, git 201 MAD (50 N	,	114	4b. City, Town, or			4c. County of De	ath
	Funeral Director		Social Security Number     6.	Sex. 7. Age (In	yrs. last birthday)  Yrs.		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day)	9. Bi	irthplace (State or Foreign Country)  MD,
	nyland how		Usual Residence of Decedent  10a. State  10b. County		c. City, Town or Lo			100:00 17		10d. Inside City Limits
	h the Ma r 28e-f s	Director	MD. FREDE		EREDER	10f. Zip Code		10	g. Citizen of What C	1  Yes 2  No Country?
	eath wit		201 MAD 150)	V ST. AOT	/		1701	Pagifu Van or No	USA 14. Race - Am	orican Indian
980	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show disal Examilied at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)	Black, Wh	ite, etc.
21215-0036	c * 6	Completed	15. Decedent's 8 (Specify only highest gi Elementary/Secondary (0-12)		(Give	dent's Usual Decupa kind of work done of DO NOT use retired	turing most of wo )	rkina	6b. Kind of Busines	
	othe othe	Be Co	17. Father's Name (First, Middle, Las		JEU	= tmpli	18. Mother's Nar	me (First, Middle, Ma	aiden Surname)	KMENT
Maryland	should b and Ments s marked	To	DAVID EUCK V 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii			WARFI		Zip Code)
	1 and 2 Health em 27 i		DEBRA  20a. Method of Disposition	NOODYARC	201 Ob. Place of Dispo		IST ADI	-	OLRICAL Oc. Location - City o	mo 21701
Baltimore	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	camatery, crai	natory or other place	. OCT.	6,2006	NESTMIN	STER MO.
Ball	permit Depart Import any in		21. Signature of Funeral Service Lice	Pollis	22	2. Name and Address	SOUN S	ARYL. RE	ERICR	IN. iteme ZITOI
	Priysician		23a. Parí1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	applications that caused the rone cause on each line.  DEFEUSE					et,	Approximate Interval Between Onset and Death SMCNTHS
ı	/Medical Examiner		resulting in death)	Due to (or as a co						STRONT
	sit s	lner	Sequentially list conditions, if y is a first cause. Enter Underlying Cause. (Disease or injury	b. Due to (or as a co	nsaduence of					
8760,	cate be executed physician and the burial-transit	al Examin	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
9	ing phys	Medical	IF FEMALE:	_ d						
.O. Box	that the death certificated by the attending of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
<u>α</u> ,	es be	þ	Part II. Dther significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	on in Part I.	23e. Did toba 1 ☐ Yes	A	o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performs	prior to death?	utopsy findings available completion of cause of
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	it 3□ DOA Dthe	_	one Sesiden	ne 6 Other /Sne	anity)
ion of	ding h. After fune	ertification; T	27. Manner of ceath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injury Work	at	28d. Describe how		outy)
Division	el or Atten	Certiflo	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		At home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical (	29a. Certifier (Check only one) Certifying P	nysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, death mination and/or in	occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the cau rred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
i	To the within 2 To the complet	Me	29b. Signature and ting of certifier	Honor,	np	29c. License	number 3/76/	290	Date signed (Mon.	th, Day, Year)
1			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) W. FG1	ENTH	ST. FR	EDERICK	- MD 21201
	Sta Registr	- 5	31. Date filed (Month, Day, Year)  OCT 0 3	completed cause of death 2 Co NNSC 2005	ignature	conte	•	)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [ 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)  $2^{\frac{5}{7}}, 2006$ **Physician** 10:55AM Anthony John Walker Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6001 Muncaster Mill Rd. Rockville Montgomery 8. Date of Birth (Month, Day, Year) Dec • 29, 9. Birthplace (State or Foreign 1952 Wash. D C If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**∑**M 2□ F 53 Yrs. Wash. 220-60-0622 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or iteme 23s or 28s-f show the Modical Examiner must be notified at 1 XYes 2 No MD Gaithersburg Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Orchard Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Geographic College (1-4or 5+) Elementary/Secondary (0-12) mailman Society 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if item 27 is marked oth eny july or other traumatic event 90cg. 18. Mother's Name (First, Middle, Maiden Surname) Leo Joseph Walker Nancy Belcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Davidson (Sister) 7402 Round Hill Rd., Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State Red men's Cemetery 10/1/06 Selbyville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Sorvice Court ee 22 Donald TosB Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. Approximate Interval Between Part 1. Enter the disease, or complica shock, or heert failure. List only one Immediate Cause (Final disease or condition resulting in death) pancreatic cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the ettending physicien and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4X Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) After this funeral of 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 XNatural 1 Tes 2 No investigation ours after death.

naral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral C completely filled 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital

The law requires that the death certificate be executed

or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760

death

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) OCT 0 3 2006

mitia M Iteliams Do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



H0058032

29d. Date signed (Month, Day, Year)

POCKVIUE WO 20055

06

•			1 - For State Registrer	State of Maryland	•	artment of I tificate of			Reg. No.	2006	32743
	Physici /Medic		Decedent's Name (First, Middle, Last)     George	Wilson				2. Date of De Month SEOTEM	ber 3	W 2006	3. Time of Death  2.35 PM
	Examin		4a. Facility Name (If not institution, give s Doctors Communi	ty Hospital			or Location of Dear anham If Under 24 Hrs		Pı	County of Death	
	Funeral Director		5. Social Security Number 6. Sex 229-40-2717	7. Age (In yrs. la	71 Yrs.	Months Days	Hours Min		ıy, Yea <i>r)</i>	Coun	lace (State or Foreign try) / A
	he Maryland Ba-f ahow outlied at	ector	10a. State 10b. County  Md. P		. Town or Lo Distr	cict He	ights		10- 000		0d. Inside City Limits 1    Yes 2   No
	h with ti	Dir	10e. Street and Number 2703 Quay Stree	t		10f. Zip Code	747		•	zen of What Cour ted Sta	•
920	d within 72 hours after death with the Maryland jiene. I then "natural", or lieme 23a or 28a-f ahow the Madical Examinar must be notified at	by Funeral Director		<ul><li>12. Was Decedent Ever in U.S Armed Forces?</li><li>1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates:</li></ul>	1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	i	4. Race - Americ Black, White, Specify: Blac	etc.
Baltimore, Maryland 21215-0036	within 72 horene. ene. than "naturi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of wo	orking		nd of Business/Ind	dustry
land 2	be file ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Last)  Eddie Montaque			Driver		me (First, Middle	, Maiden :	imster Sumame)	Union
e, Mary	is 1 and 2 should of Heelth and Men Item 27 le marke other traumatic		19a. Informant's Name/Relationship (Type Wally Wilson/so		9860	Montac	and Number or R ue Stre 33626	ural Route Numb			
Itimore	t. Page rtment o rtant: If njury or		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Ligense	Mt.	Zion		Cem. 1	0/5/06	Woo	odford, lwardsF	VA
Ba	permi Depa Impo any le		23a. Fart 1. Enter the disease, or compli	uarde	3	910 Sil	ver Hil	ll Rd.,	Sui		Md. 2074
8760,	Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien and Any sicien	ical Examiner	Mock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	Piros"	FATE	CANC	ER		Interval Between Onset and Death
Box 6	ath certific ttending p for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у		2	3d. Date of delive	ory Day Year
rds, P.O.	w requires that the de been signed by the s should be detached t	ρ	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the u	nderlying cause gr	ven in Part I.	23e. Did 1			ne cause of death?
Vital Records,		Completed						24a. Was auto perfo 1 \( \text{Yes}		prior to cor death?	psy findings available inpletion of cause of
	Phyelcian: T this certificet ral director, pi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 1 Inpatient 2 I	ER/Outpatier	it 3 DOA Ot	200	ath (Check only only only only only only only only		i □Other (Specify	()
Division of	ling After une	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	M 1	ry at rk? ]Yes 2 □No	28d. Describe		occurred  Number or Rura	I Route Number
<u>&gt;</u>	e Hoepital or Attend 1.24 hours after death e Funerel Director: . letely filled in by the f	al Certif	4 Homicide determined	building, etc. (Specify	viedge Jaati	r occurred at the t	ine, data and plac	City or To	wn, State)	and manner as st	atad.
•	To the He within 24 To the Fu	Medical	(Check only 2 ☐ Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	ion and/or in	29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
•	Sta Regist		30. Name and ddress of person who co	32 Registrar's Signat	W	Print)	diver 1	Sel Sit	e3, l	Cherry	, 11D 2014)

Ronald Eugene Buckmon 06-07596 UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 32744

		- For State Registrar			Cer	tificat	e of L	Death				f	Reg. No.			) 0;	- / 4 '
Physicia		Decedent's Name (First, Mi	ddle,Last)								2.	Date of De Month		Year		3. Time of De	
Medical Examir		Ronald E	ugene	Buckm	on							October	B, 2006	rear		1936 hr	s
- Marie	•	4a. Facility Name (if not institu	tion, give st	reet and num	ber)		4b	. City, Tov	vn, or Lo	ocation of	Death		4c. (	County of	Death		
		Pennsylvania Avenu	ie Eastbo	ound				Forestv	ille				Pri	ince Ge	eorge'	S	
Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs. I	ast birthd	ay)	If Under	1 Year	If Under	24Hrs	8. Date of B	irth(MM/DI	D/YYYY)	9. Birth	place (State	or
Director		F70 70 F/00		2 F	52		.,,	Months	Days	Hours	Min.	09/16	/105		Foreign	ntry) SC	
	L	579-72-5402	IAM	2	52		Yrs.					09/10	11 193	4			
<u>&gt;</u>		Usual Residence of Decedent  10a. State 10b. Coun	hy	_	10c. City,	Town or	Location	າ							$\overline{}$	10d. Inside C	ity Limits
w any	- 1		,		roc. Oity,										- 1	1 X Yes	
and f sho	5		ce Ge	orge's		For		ville									2
Maryland 28a-f show d at once.	Director	10e. Street and Number						10f. Zip C	ode				10g. Citize	en of Wha	at Count	ry?	
ith the Maryland 23a or 28a-f sho n tifi d at once.	ੋਂ∣	3327 Walter	s Lan	e #T-	2			20	747				1	USA			
with th	Funeral	11. Marital Status	1:		dent Ever in U	.S. 1						ify Yes or N	lo- 1			an Indian, Bla	ack,
eath iten	림	1 Never Married 2	Married	Armed For	ces? 2 X No		If Yes	s, specify (	Cuban, M	Mexican, I	Puerto Ri	ican, etc.)		White,	etc.		
ter d		3 Widowed 4 X	Divorced If \	Yes, Give Year	2		1 Y	es 2 X	No	specify:			s	pecify:	В1	ack	İ
2 hours af "natural	<u>\$</u>	15. Decedent's Education (S		Dates: highest grade	completed)			S Usual Oc					16b. Kir	nd of Bus	iness/In	dustry	
2 hou	Completed	Elementary/Secondary (0-1	2)	College (1-4	4 or 5+)	du	ring mos	st of worki	ng life. D	OO NOT u	se retired	d)	1				- 1
136 thin 7. than than	희			2		Sto	ock (	Clerk	2				P.	riva	te		i
there is a second of the secon	탉	17. Father's Name (First, Mide	ile, Last)						18	3.Mother's	Name (F	irst, Middle	Maiden S	urname)			
115 effle al Hy ed o	Be	James C. Buc	kmon							Ros	sali,	e Sass	stort	a c			
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	0	19a. Informant's Name/Relation		e, Print )		19b.	Mailing A	Address	(Street a			ral Route Nu			, State,	Zip Code)	
shot and I		Brenda Buckm				300	nn 21	Oth S	itra	et NI	F • W:	ashing	rton	חר י	2001	8	
nnd 2 and 2 earlth	H	20a. Method of Disposition	011/ 11/	A WIIC	20b.			on (Name				Date				own, State	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be no tife d at once		1 X Burial 2 Crema	tion 3	Removal from	m State	cremator	y or othe	er place)					ł				
Page nent ant:		4 Donation 5 Other	Specify:		Ft	. Li	ncol	n Ce	mete	ry	10/2	1/200	6 Bre	ntwo	od,	MD	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mec	ſ	21. Signature of Funeral Serv						me and A		•			831 G	eorg	ia /	Avenue	N.W.
<b>0</b> 89 8 8	-1	Kerlph Mil	Corema	2)				ney'					ashin	gton	, DO	C 200	11
Physician		23a. Part I. Enter the disease failure. List only one car			used the death	. Do not	enter the	mode of	dying, si	uch as ca	rdiac or r	espiratory a	rrest, shoc	k, or hea	rt	Approximat Between C	
/Medical	-	Immediate Cause (Final dise	3.4.	ultiple Inju	ries											Dea	
Examiner	- 1	or condition resulting in death			consequence o	of):									$\neg$		
~		Sequentially list conditions,	b														
	ĕ	if any, leading to immediate		e to (or as a	consequence o	of):											
	힏	cause. Enter Underlying Cau (Disease or injury that initiate	d <sup>C.</sup> —			Λ.									_		
og sq	Examiner	events resulting in death) La	31	e to (or as a c	consequence of	ונ).											
8760, ificate be executed as physician and is the burial - transit	평	UNPENDED	d	AMENDED											-		
be es	n/Medical																
8760, tificate be ng physici as the buri	Ĕ	IF FEMALE: 23b. Was decedent pregnant			utcome of preg				3	Estania	pregnano			Date of o	delivery Da	0.4	Year
68 certif	ä	past 12 months?	i	1 Live bit	nt at time of d	2 ( eath <sub>5</sub>	Feta			Ecrobic	pregnant	<b>-y</b>	"	VIOTILIT	De	зу	1 eai
Box 68 e death certi the attendin	/sic	1 Yes 2 No 9	Unknown	9 Unknov		5 [	Otne	er (Specif	y)								
• E > E	Physicia	Part II. Other significant cor	iditions co	ontributing to	death but not	resulting	n the un	iderlying c	ause giv	ven in Par	t I.	23e. Did	tobacco u	se contrit	oute to the	he cause of o	death?
Division of Vital Records, P.O.  Blorstion of Vital Records, P.O.  al or Attending Physician: The law requires that it as after death.  al Director: After this certificate has been signed be led in by the funeral director, page 2 should be detax	Ď											1 □ Y	es 2 🗸	No 3	Proba	ably 4 L	Jnknown
S, juire: an sig	Completed		_									24a. Wa	san	24h W	lere aut	opsy findings	available
ord w red	be											aut	opsy	pr	rior to co	ompletion of	
ec.	E											1 V Yes	formed?		eath?	s 2	No
In: T	O	25. Was case referred to med	lical					26	.Place o	of Death (	Check on	nly one)		-l			
/ita	o B	examiner?  1 ✓ Yes 2 No	Hos	spital: 1 Ir	patient 2	ER/Out	patient	3 DO	A C	Other <sub>4</sub>	Nursing	Home 5	Residen	ice 6 🗸	Other	Scene	0.5
S. Phy	-	27. Manner of Death		28a. Date of	of Injury	28b. Ti	me of Inj	ju <b>ry</b> 28	c. Injury	at Work?		8d. Describ					
nding	<u>.</u>	1 Natural 5 F	ending	FOUND:		FOUN			1 Ye	es 2 🗸	No P	'edestriar	1 struck	by mot	orcycl	е	
SIC SIC	g		nvestigation	28e Place	of Injury - At h	1936		factory	office bu	ildina etc	2	8f Location	(Street an	id Numbe	r or Rur	al Route Nur	mber City
J— E in the in in in in in in in in in in in in in	튑		ould not be etermined		Major Roa			.,				or Town	State)			nd, Forest	
spits hours	ပီ	4 Homicide															tvine, ivi
n 24 n 24 re Fu	cal	(Check only	-		of my knowled f examination	_											
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate hompletely filled in by the funeral director, page.	Medical Certification:	2	_ a	nd manner st			Jongan				-31150 at	oo, ua					
	Σ	29b Signature and title of ce	titler	1/2	$n \cap$					number						th, Day, Year	)
		1 War		1110	IV DL	1		_	O.C.N	A.E.			Octo	ber 9, 1	2006		
2		30. Name and address of per	son who co	mpleted caus	e of death (Iter	n 23a)			_								
V		Carol Allan, MD	Assistant	Medical I	Examiner	111 F	enn S	treet, B	altimo	re, MD	21201						
S	ate	31 Date filed (Manus Day, Ye	7 200		gistrar's Signa	ture	Bros	M. 3									
Panis		940 L	6 Pron	Jan A	Silver was	and the	The state of the state of	Share re-									

			1 - For Stete Registrer	State of Marylan	id / Depa	artment of He rtificate of De	alth and N eath		iene (	006	32745
E	Physici		1. Decedent's Name (First, Middle, Las	st) «	BRA	DSHAN	/	2. Date of Dear Month OCTOR	th Day	Year 2006	3. Time of Death 7:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give ROCKGLEN NURS		/ 0/ /</td <td>4b. City, Town, or Lo</td> <td>ocation of Death</td> <td></td> <td></td> <td>Inty of Death</td> <td>(100</td>	4b. City, Town, or Lo	ocation of Death			Inty of Death	(100
	Funeral	. e <sup>ee</sup>	Social Security Number 6. S				If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) _	•	ace (State or Foreign
	Director		241 · 24 · 1405 Usual Residence of Decedent	97	Yrs.			06.20	1909		NC
	Aarylan I show	ŏ	10a. State 10b. County NA		y, Town or Lo TI MORE					10	od. Inside City Limits 1   Yes 2   No
	r 28a-	Irect	10e. Street and Number	OAL	imore	10f. Zip Code		1	0g. Citizen	of What Coun	try?
	ath wit	raiD	4623 COLEHERN	<del></del>		2122	19			USA	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	8	Race - America Black, White, e BLA(	etc.
2	72 ho	eted	15. Decedent's Ec (Specify only highest gra		(Give	ient's Usual Occupation		king	16b. Kind o	f Business/Ind	
2121	d within giene. or than	Completed	Elementary/Secondary (0-12)  91H GRADE	College (1-4or 5+)		DD NDT use retired) 1E MAKER			DO	MESTIC	L
pue	l be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last) LASSITER MATTE				_	ne (First, Middle, I		name)	
aryla	2 should and Men le marke aumatic	၉	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street and		COLEFII ral Route Number		wn, State, Zip	Code)
Ž,	and 2 ealth a m 27 le		VIRGINIA PRICE	(DAUGHTER)		COLEHERA	JE RD.	BALTO			
Baltimore, Maryland 21215-0036	Par true		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Fugeral Service Licen	Removal from State  ()	emetery, crer ODLAN I	sition (Name of natory or other place)	10.10	1.06	3ALTIN	ORE	MD
Ba	permit. Departr Importe any Inju		2 augun C	- A	γÃ	Name and Address (UGHN C. G. BALTO.	REENE NATI: DI	FUNERAL	SER	VICE D 2122	q
). 	Physician /Medical Examiner	ler	23a. Part. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list rend tens if any, leading to immediate	blications that caused the death one cause on each line.  a. SEPS  Due to (or as a conseq  Due to (or as a conseq  Due to (or as a con eq	. Do not ent	er the mode of dying,	such as cardiac	or respiratory arri	est,		Approximate Interval Between Onset and Death
8,0928	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq							
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 [M] No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)				Date of deliver	y Day Year
ds, p	signed b	d by PI	Part LOther significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause given	in Part I.	23e. Did tob			e cause of death?
Vital Records,	aw requir s been si 2 should	plete	Carensmi	of Color	2			24a. Was a	n 24	b. Were autop	sy findings available
<u>~</u>	Physicien: The lav this certificate has al director, page 2 :	Сош		1				autops perform	ned?	prior to com death? 1 ☐ Yes	pfletion of cause of 2 🗌 No
Vita Sita	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ED/O	Othos		th (Check only on			
n of	ing Phys	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	t	ome 5 Reside			)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str		s 2 No	28f. Location (St. City or Town	reet and Nu. n, State)	mber or Rural	Route Number,
	he Hospite n 24 hours he Funerel pletely filler	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, restigation, in my opin	date and place, ion, death occur	and due to the cared at the time, da	ause(s) and ate and plac	manner as sta e, and due to	ited. the cause(s)
)	To t To t	Σ	29b. Signature and title of certified	kare		29c. License n				ned (Month, E	
	7		30. Name and address of person who	completed cause of death (Item	2	Printille	M A	T BAI	-T1,410	RE /	200 b 4D 21229
3.2	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture			7			
DH	MH 17 Rev 1/20	198	001172	UUO   Plater	St. John	man p					

ORIGINAL

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 6

32746

				State of Marylar	Certifica				Reg. No.	00	0 %	140
	Physici		Decedent's Name (First, Middle, Later CATHERINE M.					2. Date of Dee		2 <sup>Y</sup> 8°06	3. Time	of Death 15 PM
1	/Medio Examir		4a. Facility Name (If not institution, give			4	b. City, Town, or L		4c. County	of Death	ro	
	Funeral		Holly Hill Ma 5. Social Security Number 6. S 215-58-4432		last birthday) If Und Yrs.	der 1 Year ns Days	TOW  If Under 24 Hrs. Hours Min.	son  8. Date of Birth  July 10 and 10				e or Foreign
	Director	118	Usual Residence of Decedent					- 2	, 1910	Mai	утаг	Iu
	e Marylan a-f show	ctor	MD 10b. County	altimore 10c. CH	ty, Town or Location Park	ville				10		City Limits as 212 No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 8502 James Ave	nue	10f. :	Zip Code 21	234		10g. Citizen of \		ry? SA	
020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Hems 23a or 23a-f show event, the Medical Examiner must be netted at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1  ☐ Yes 2 ☑No If Yes, Give Year or Dates:		cedent of Hi pecify Cubar : 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Blad Specify	e - America ck, White, e		
Maryland 21215-0020	within 72 ho ene. than "natur ne Medicel	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	16e. Decedent's U: (Give kind of life. DO NOT House			ring	16b. Kind of B	denc	-	
land 2		To Be Co	17. Father's Name (First, Middle, Last) George Nelson				18. Mother's Nam Anna D		Maiden Suman	10)		
Mary	nd 2 sh alth and 27 Is m r traum		19a. Informant's Name/Relationship ( Barbara Cunnin	<sub>Турө, Print)</sub> gham-daughte	19b. Mailing Address: 3123½ Wi							34
Baltimore,	Pages 1 en ment of Heali ant: If Item 2 ury or other		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State MO1	Plece of Disposition (A cemetery, crematory of celand Memo		1	01/8/	20c. Location - Parkvil	le,Mai	rylar	
Balt	permit. Pages Department of Important: If It any Injury or once.	17	21. Signature of Funeral Service Licer	Nº Fredol	22. Name 8800 Park	and Addres Harfo Ville.	s of Facility EVA ord Road MD 21234	ns funei	RAL CHA	PEL AI	VD CR	EMATION ERVICES
	Dhysisian	8 104	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not enter the m	node of dying	g, such as cardiac	or respiratory ari	rest,		Approxim Interval B Onset and	letween
1	Physician /Medical Examiner		Immediate Ceuse (Finet disease or condition resulting in death)	a advance	or as a consequence of	<u></u>	utia				10 y	euss
	B // iš	Examiner		b								
90,	oe execu cian end vurial-tra		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead on the cause)	Due to (c	or es a consequence o	of):						
x 68760,	death certificate be executed eattending physician end-	<b>VMedical</b>	that initiated events resulting in death) Last	Due to (o	or as a consequence o	of):						
. Box	death e atter	Physician/	Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlying	g cause give	en in Part t.	23b. Did to	obacco use co	ntribute to 1	the caue	e of death?
P.O.	that the ned by the detache	by Phys						1 □ Y	es 2□ No	3 ☐ Probe	ibly 4	⊡Unknown
of Vital Records,	The law requires that the death certe has been signed by the attendings 2 should be detached for use	Completed b						24a. Was a perfor		com	e autops lable prio pletion of eath?	r to
E R		Com						1□ Y	es 2⊠No	10	Yes 2	□146o
Vita	Physician: this certifice ral director, I	æ	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat					
of	this ai di	. To	1 ☐ Yes 2 ☑ No  27. Menner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 3 28b. Time of		4 1 Nuising no	ome 5 Residence 128d. Describe h				
Division	Attending I or death. ector: After by the funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Pay Year)	Injury M	28c. Injury Work 1 🗆 \	? ∕es 2□No					
Divi	글목목	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact	tory, office		28f. Location (S City or Town		er or Rural	Route Nu	mber,
	e Hospital 124 hours e Funeral I	edical		ysician: To the best of my kno niner: On the basis of examina and manner stated.								ı(s)
	To the within 2 To the Comple	Me	29b. Signature end title of certifier	My mo	2	29c. License	number (\ \ \ \ \ \ \ \ \	2	9d. Date signe	d (Month, D	1	
	6		30. Name and address of person who	completed cause of death (Item	n 23a) (Type Print)	10	usm. Il	W 7	1704	/		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	00	- / 000 0	- 4 0				

Catherine

			1 = For State Registrar	State of Maryland / Depart	tment of Health and Mificate of Death	ا Mental Hygien هور Neg. N	ZUUh	32747
1,20	Sign.		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		FRANCES	BRADSHAW		OCTOBER 15	2006 Year	11:15 P M
	Examin		4a. Facility Name (If not institution, give s	,	4b. City, Town, or Location of Death	4	c. County of Death	
		· ja		AND REHABILITATION	FOREST HILL  If Under 1 Year   If Under 24 Hrs.	O Date of Birth	HARFORD	100
	Funeral Director	1	5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthp	10 - 40 - 1 / /
			Usual Residence of Decedent			201712	X IUU	magon, D
	anylan show	_	10a. State 10b. County	10c. City, Town or Loca	*		1	0d. Inside City Limits 1  Yes 2  No
	Ba-1 cutilis	Funeral Director	MIZ	DH	LTIMORE		21.	
	with t	בֿב	10e. Street and Number	Aug	10f. Zip Code	10g. C	itizen of What Cour	itry ?
	ne 23	era	11. Marital Status	2. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ	
9	or ite		1 Never Married 25 Marned	1 □ Yes 2 □ No	∕es, specify Cuban, Mexican, Puérto □ Yes=2 <b>∦</b> No — <i>Specify:</i>	Rican, etc.)	Black, White.	etc.
99	filed within 72 hours after death with the Maryland Hygiene Hygiene the the White the the White the Marical Examinet in Marical Examinet in the molified at	d by	3 Widowed 4 Divorced	Year or Dates:	THIS ZALINO Specify.		Specify: W	rite.
7	n 72 ł "nati	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give kir	nt's Usual Occupation nd of work done during most of worl O NOT use retired)	sing 16b.	Kind of Business/In	dustry
7	withii iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1/	0	thoma	
פ	2 should be filed within 72 hours after death with the Marylan and Menther Hygiene Hygiene is marked at Hygiene "ratural", or iteme 23a or 28a-1 show aumatic event, Ita Marilcal Examination must be motified at	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	n Surname)	
<u>yla</u> ı	should be and Mental I s marked o	To	Samuel Ber	aer	Flore	nce Sa	chs.	
Maryland 21215-0036	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	4	9a. Informant's Name/Relationship (Ty	e, rint) 19b. Mailing	Address (Street and Number or Ru.	ral Route Number, City	or Town, State, Zip	Code)
	1 and 1 Health em 27 ther tra		1 COL NOU O I MAD 202. Method of Disposition	20b. Place of Dispositi	Light Side UK,	Date 20c. I	ocation - City or To	J 21059
ğ	B O		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	cometent croma	tory or other place)		rest Hi	The state of the s
Baltimore,			21. Signature of Funeral Service Ligense	TO TO	Name and Address of Facility.	1 /00 /0	1451 11	es Besti
ñ	permit. Departr importi eny inj		Kunheder 1	Savidiu 31	ns runeral Chap	cest Hill	2016 AM	20.
	7		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not enter	the mode of dying, such as cardiac			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	metastatis a	uncer			Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	è.	5	Sequentially list conditions, b	Due to for as a consequence of				
	uted ansit	Examiner	Sequentially list conditions, fair, eating to innine late cause. Enter Underlying Cause (Disease or injury that initiated events	,				
ó	s be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):				
8760	ate hy the	dical						
9 ×	entific ding p	/Mec	IF FEMALE:	Po If you outcome of programmy				
Вох	eath certific attending p	Physician/Me	in the past 12 months?		ctopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
o.	at the de by the	ysle	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	Sillor (Specify)			
ď.	The law requires that the te has been signed by th bage 2 should be detached.	by PI	Part II. Other significant conditions con	tnbuting to death but not resulting in the unde	ertying cause given in Part 1.	23e. Did tobacco	use contribute to the	ne cause of death?
ğ	w require been sig should b					1 ☐ Yes	2 □ No 3 □ Prob	pably 4 Unknown
ecc	lawr las be	Completed			<del></del>	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Con				performed? 1 ☐ Yes 2 ☐ N	o death?	2 No
Division of Vital Records,	il or Attending Physician: The after death. Director: After this certificate in by the funeral director, pagin by the funeral director, pagin by the funeral director.	Be	25. Was case referred to medical examiner?	ospital:		th (Check only one)		
ō	Phys ar this eral dir	2: 10	1 ☐ Yes 2 ☐ No	28a. Date of Injury (Month, Day Year)  28 EP/Outpatient 28b. Time of Injury	3 DOA Other: 4 Nursing He	ome 5 ☐ Residence 28d. Describe how inju		/)
<u>o</u>	nding F ath. r: After e funeri	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
<u>S</u>	or Attendater death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	ot, factory, office	28f. Location (Street a City or Town, Sta		I Route Number,
	oitaí o urs aft rrai Di iled ir							
	Hospital     24 hours     Funeral letely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, death o ler: On the basis of examination and/or invest and manner stated.	occurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause( red at the time, date ar	s) and manner as sind place, and due to	ated. the cause(s)
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	Mec	29b. Signature and title of certifier	and marrier states.	29c. License number	29d. D	ate signed (Month,	Day, Year)
	I.		Davids	D	032255	Dr.	rober 16	2001
	,0		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Pri				
		-,-,-		15 W. MACPHAIL ROAD,		AIR, MD 21	.014	
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 2006	32. Registrar's Signature				
	A CONTRACTOR OF THE PERSON OF	197	001212	All and a second				1

			1 - For State Registrar	State of Mary	Ce	ertificate of	Death		leg. No.	5 32/48
	Physici	an	Decedent's Name (First, Middle, La     Rose M. I					2. Date of Dea	Day Year	/ / / ~ ~ ~
	/Medic Examin	al	4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death	Wtob	4c. County of De	
	LXaiiiii	CI	Franklin Squar	· ·	1	Rose	dale		Baltim	ore
	Funeral Director				n yrs. last birthda 89 Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day Nov • 24	,1916 9. B	rthplace (State or Foreign PA
	iand ow		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or	Location				10d. Inside City Limits
	a-f sh	ctor	MD Baltin	nore	Esse	<b>X</b>				1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show [must be notified at	Funeral Director	10e. Street and Number 1507 Lanflair	Road		10f. Zip Code 2122	1		10g. Citizen of What C USA	Country?
2-003p	after or Ite	by	11. Marital Status  1 □ Never Married 2 □ Married  3X Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or in U.S. 13	B. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
2	within 72 hours ene. then "neturel", he Medical Exe	etec	15. Decedent's E (Specify only highest gra	ducation a <i>de completed)</i>	(Gi	edent's Usual Occup re kind of work done DO NOT use retire	during most of work	ung	16b. Kind of Busines	•
7 7	d withir jiene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  2yrs		cretary	0)		State o	
/land	id be filed ental Hygic ked other ic event,	To Be C	17. Father's Name (First, Middle, Last, Charles Echa	, -			18. Mother's Nam unknow		Maiden Sumame)	
Mar	and 2 should ealth and Mer n 27 is marke	_	19a. Informant's Name/Relationship ( Rosemary Brotz						r, City or Town, State, timore Mi	
more,	iter		20a. Method of Disposition  1 National 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	cemetery, ci	position (Name of ematory or other pla In Cemete	ce)	Date 16/06	20c. Location - City of Baltimore	
Баппог	permit. Page Department of Important: ff any injury or once.		21. Signature of Funeral Service Legal			22. Name and Addre	50		Ave. Ba	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not a					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acu	e m	poland	ial uy	ancho	m	Onset and Death
	Examiner		- 1	Due to (or as a c	onsequence of): '	Arte	ry I	rises	10_	un-known
	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):		<del></del>		-	
V	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):					
58/6U,	tificate be executed g physicien and as the burial-transit	ledicai E	(	d						
O. Box o	death cer e ettendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death	Ectopic pregnanc	у		23d. Date of do Month	elivery Day Year
as, r	juires that n signed b	ρ	Part II. Other significent conditions of University Fre	1	ot resulting in the		ven in Part I.			to the cause of death? Probably 4 DUnknown
viiai necords,	The law requires that the ste hes been signed by thi bege 2 should be detache	Completed	Ocheoperos	is.				24a. Was a autop: perfor	med? prior to death?	
<u> </u>	entifice octor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes th (Check only or		s 2 No
	iding Physician: th. : After this certifice i funeral director,	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpati	BIIL 3L DOA			ence 6 Other (Sp	өсіfу)
0	Attending ir death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	ear) Injury	Wo	rk?  Yes 2   No	200. Describe III	ow injury occurred	
DIVISION OF	al or Attendi efter death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, Specify)	street, factory, office		28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours efter deat! To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	nysician: To the best of n miner: On the basis of ex and manner stated	ny knowledge, de amination and/or f.	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	U D		29c. Licens	se number	-ZJ 2	9d. Date signed (Mor	nth, Day, Year)
			7000		h (ltor oo: ) T	D-	20 /3	7	10-13-	- 2006
	5		30. Name and address of person who MALL KA  31. Date filed (Month, Day, Year)	ASEM  32. Registrar's	. 70°	EAST	BRN R	NUD.	MD-2	ne to the cause(s)  oth, Day, Year)  - 2006  21221.
÷	Sta Registr		OCT 1 7 2	006 32. Hegistrar's	Signature,					

DHMH 17 Rev 1/2001

	. 7	•	-	-
State of Maryland / Department of Health and Mental Hygiene 2	1 8	3	f 1	8
State of Maniand / Department of Health and Mental Hydione /	- 1		1 1	10
State of Marytanu / Department of Health and Mental Hydrefler		ă-		1
, , , , , , , , , , , , , , , , , , , ,		,,,,	4	- %

			1 - State Registrar	State of Wil	arylaria /		tificate of E			eg, No.	000	32143
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					<ol><li>Date of Deat Month</li></ol>	Day	Year	3. Time of Death
	/Medic		William Howard B						October		2006	8:10 A. M
1	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town, or				nty of Death	
			426 Montemar Ave 5. Social Security Number 6. S		e (In yrs. last	hirthday)	If Under 1 Year	nsville If Under 24 Hrs.	8. Date of Birth		altimo	
	Funeral Director			ØM 2□F	88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 9/19/	1918		place (State or Foreign ntry) sylvania
	/land		10a. State 10b. County		10c. City, To	own or Lo	cation	<del></del>			1	0d. Inside City Limits
	Man	ţō	MD Baltime	ore			Catonsvi	11e				1 ☐ Yes 2 No
	or 28s	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cour	ıtry?
	th will	alo	426 Montemar Ave	•			212	28		U.S	S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give	40	1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		lace - Americ Black, White, cify:	etc.
21215-0036	turai	pa pa	15. Decedent's Ec	Year or Dates:		6a Dece	lent's Usual Occupa	tion		16h Kind of	W N Business/In	ite
7	in 72 n n	Completed	(Specify only highest gra	de completed)		(Give	kind of work done d OO NOT use retired)	uring most of worki	ing	166. Killu ol	Business/iii	Justry
7	with Jene	E O	Elementary/Secondary (0-12)	College (1-4or 5		isab	ility Con	sultant		U.S.	. Govt	•
ק	e fifec I Hyg othe	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle, I			
<u>a</u>	uid by Aenta rked ric e	To B	William Brassing	ton				Carrie E	Berry			
Maryland	nd 2 sho alth and P 27 ie me		19a. Informant's Name/Relationship ( Mary Lou Brassin	• • • • • • • • • • • • • • • • • • • •			ng Address <i>(Street a</i> Montemar					Code)
altimore,	Pages 1 a lent of Hei nt: if item ry or othe		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification 1)		ceme	atery, crer	sition (Name of natory or other place ematory	) !	0ate 4/2006		n - City or To	
Balti	permit. Departm Importe eny inju		21. Signature of Euneral Service Licer	Palroce	she							-Witzke Edmondsor
68760, 6	death certificate be executed  E x x x	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lin	a consequence	ce of):		NELM			ć	Approximate Interval Between Onset and Death
.O. Box	the death certifi y the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3 🗆	Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
<u> </u>	quires that the de n signed by the a ld be detached f	þ	Part II. Other significant conditions of ALZHEIM		ut not resultin	g in the u	nderlying cause give	n in Part I.	23e. Did tot	*****		ne cause of death?
Records,	ysicien: The law requires that the is certificete hes been signed by th director, page 2 should be detache	Completed				· · · <u> </u>			24a. Was a autops perform	y	b. Were auto prior to con death? 1 ☐ Yes	psy findings available mpletion of cause of
<u>a</u>	ilen: ortifice ctor, i	Bec	25. Was case referred to medical examiner?					26. Place of Death				
<u>&gt;</u>	Physicien: r this certifice ral director, p	일	1 ☐ Yes 24 No		nt 2□ER/	Outpatien	t 3 DOA Othe	r: 4 ☐ Nursing Ho	me 5 Reside	ence 6 🗆 C	Other (Specify	y)
Division of Vital	Attending P or death. ector: After t by the funera		27. Manner of Ceath  1 Natural 5 Pending 2 Accident investigation		b. Time of Injury							
Divis	2 = = -	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Nu n, State)	mber or Rura	l Route Number,
	To the Hospital of within 24 hours of To the Funeral Completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurr	and due to the ca ed at the time, d	ause(s) and ate and plac	manner as st	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	21-1			29c. License				ned (Month,	
,	\		· Cle C	DU M	LD		014	354		10/12	3/200	6
	10X1		30. Name and address of person who $E_{i} w$ , $COLE_{i}$	completed cause of de ST AG NE	- 1	a) (Type,	Print) CATON A	VE BAL	TIMOR	EM	02	1229
1	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7	32. Registra	ar's Signature		bout					

DHMH 17 Rev 1/2001

W. HOWARD BRASSINGTON

		ľ	For State Ragistrar	State of	Maryland	d / Depa <i>Cei</i>	artment rtificate	of He	alth a eath	and M		jiene 1eg. No.	006	32750
			1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month		Vear	3. Time of Death
	Physicia /Medic	4	Edna C. Bryant								Octobe	r 13,	, 2006	5:25 P M
	Examin		4a. Facility Name (If not institution, give					Town, or L				4c. C	County of Deat	
			Frederick Vill					tons					Balti	
	Funeral		5. Social Security Number 6. S	ex	'. Age (In yrs. la	ast birthday) Yrs.	If Under Months	Days Days	If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birt <i>C</i> o Mar	hplace (State or Foreign untry)
	Director	-	220-48-5162 Usual Residence of Decedent		96	110.					Sept.	10,13	710 Mai	yrand
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary	ğ	Maryland		Ba	ltimor	:e							11X Yes 2 ☐ No
	r 288	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	untry?
	7 wit	a D	522 Old Orchard	Road				2122	29			USA	A	
	deal	Funerai	11. Marital Status	12. Was Deced		S. 13.	Was Deced	ent of Hisp	panic Ori Mexican	gin? (Spe	cify Yes or No- Rican, etc.)	1-	4. Race - Ame Black, White	
9	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	2 X No		1 ☐ Yes 2		Specify:					nite
21215-0036	be tiled within 72 hours after death with the Maryland hat Hygiene. ed other than "naturel", or teme 23e or 28e-f ehow event, the Medical Examinar must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dat	tes:									
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usua kind of wor DO NOT us	l Occupati k done dui	ion <i>ring</i> mos	t of workir	ng	16b. Kin	d of Business/	Industry
12	withir	Ę.	Elementary/Secondary (0-12)	College (1-4	4or 5+)							0	n Home	
2	e filed withi al Hygiene. I other than vent, it a M		17. Father's Name (First, Middle, Last)	1		HOI	nemake		8. Mothe	er's Name	(First, Middle,			
Maryland	~ - 0 =	To Be	E. Raymond Carm	ichael					Ed	na C.	. McShe	rrv		
2	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street an			/ Route Numbe		Town, State, 2	Zip Code)
<b>S</b>	nd 2 alth a 27 is r trau		Robert S. Bryan	t So	on	522	01d C	rcha	rd R	oad;	Baltim	ore,	MD 212	.29
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked eny Injury or other traumatic evonce.		20a. Method of Disposition			ace of Dispo	sition (Nam	e of ther place)	1	D	ate	20c. Loc	ation - City or	Town, State
E	Page nent con int: If		1 □ Burial 2 ♠ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		tate	ro Cr			1	0/18	/2006	Cato	nsville	, Maryland
ati	ports ports y Inju		21. Signature of Funeral Service Licer	nsee .	A	22								ab Witzke
ω_	89689		1 ull		10128	<b>ပ</b> ် 1	630 E	dmond	dson	Aver	ue: Ca	onsy	rille.	MD 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the death ch line.	. Do not ent	er the mode	of dying,	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Ath	erosc	lerot.	ic	Car	dior	tasc	15/0	Nic	Page,	Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ence of):			4-1	23	- 1 0 3		L WAS	
	LXamine		Sequentially list conditions,	b. De	ment	Lia.								8 years
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	or as a consequ	ence or):								
20	be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ence of):								
8760,	ate be executed hysicien and the burial-transit													,
687	ficate p phys	Physician/Medical		_ 0										
Box	n cert	≥	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7					2:	3d. Date of del	ivery
œ.	death e ette	icia	in the past 12 months?	4 ☐ Pregna	th 2 ☐ Fetal Int at time of de		Ectopic pro Other (sp						Month	Day Year
P.O.	at the by th	hys	9 Unknown	9□ Unknov										
S,	es tha	ξ	Part II. Other significant conditions of	ontributing to dea	ath but not resu	lting in the u	nderlying ca	ause given	in Part I	•				the cause of death?
ord	equir sen s	ted			<del>,</del> .						1 U Y	es 2)K	INo 3∐Pr	obably 4 Dunknown
Division of Vital Records,	law les by	Completed									24a. Was autop	sv	24b. Were au	topsy findings available completion of cause of
Œ	The page	ပ္ပ									perfor 1 ☐ Yes		death? 1 ☐ Yes	2□ No
<u> </u>	icten Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital: , ,				Othor			(Check only o			
of	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	1 🗆 In	patient 2 E	ER/Outpatier 28b. Time o			4 (2) 110		ne 5 🗆 Resid			cify)
Ę	ding After fune	ion	1 Natural 5 ☐ Pending	28a. Date of (Month	, Day Year)	Injury	м 2	Bc. Injury a Work? 1 □ Ye	a" es 2 🗍		.ou. Describe ii	OW IIIIJUIY	00001190	
<u>is</u>	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b	e One Place	of Injury - At hor	me, farm, str					28f. Location (S	treet and	Number or Ru	ıral Route Number,
Š	efter efter Dirs	Certification;	4 Homicide	building	g, etc. (Specify,	)	,	,			City or Ton	n, State)		'
	splte		29a. Certifier 1 Certifying Ph	ysician: To the b	oest of my knov	wiedge, deat	h occurred a	at the time	, date an	nd place, a	and due to the	ause(s) a	and manner as	stated.
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours eliter death.  To the Funeral Director After this certificate hes been signed by the ettending pi completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director.	ledicai	(Check only 2 Medical Exar	niner: On the bas	sis of examinati er stated.	ion and/or in	vestigation,	in my opir	nion, dea	ith occurre	ed at the time, o	date and p	place, and due	to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	1			29c	. License r	number	/ >		29d. Date	signed (Monta	h, Dey, Year)
			sharm ().	he Co		_ MD		03	5/	62			10/16,	106 Suite 18
	V		30. Name and address of person who			23a) (Type,	Print)	5411	0	1d	Frede	nek	Rd -	Suite 18
-	ì		Sharon J.					Ba	141.	more	Me.	2	1224	
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 7	A ST	gistrar's Signat	are	P. M. D	,						

DHMH 17 Rev 1/2001

06-07624 Donnie L. Blanding

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental

po or r rinte in Diagram in action in in			
/ Department of Health and Mental Hygiene		2000	2275
Certificate of Death	Dog No	2006	3613

		Registrar		Cerun	icale of	Death			Reg. No.	
Physicia Medical Exami	ner	1. Decedent's Name (First, Middle,Last)  DONNIE L.	BLANDIN					2. Date of De Month October	9, 2006 Yea	2014 hrs
		4a. Facility Name (if not institution, give Sinai Hospital	street and number)		4	b. City, Town, or Baltimore	Location of	f Death	4c. County o	of Death
Funeral Director		5. Social Security Number 6. Sex 1 1 X	7. Ag	e (In yrs. last i	• •	If Under 1 Year Months Day		Min.	3/1984	9. Birthplace (State or Foreign Country) MARYLANI
any		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Locatio	on				10d. Inside City Limits
× .	_	MARYLAND N/A			BALTI					1 X Yes 2 No
Maryland 28a-f show d at once.	~ L	10e. Street and Number				10f. Zip Code		-	10g Citizen of Wh	nat Country?
th the A		5255 ST. CHARLES			T	2121			U.S.	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Armed Forces?					in? ( Specify Yes or N Puerto Rican, etc.)	10- 14. Race White	e - American Indian, Black, e, etc.
after de	by Fu	3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates:			Yes 2 X No			, ,	BLACK
hours after natural", Examiner		15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	y highest grade con College (1-4 or			t's Usual Occupa ost of working life		ind of work done use retired)	16b. Kind of Bu	·
0036 within 72 hours after death with the Maryland jene. Per (han "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Completed	10th grade	College (1-4 of	,	STOC	KER			JEWIS CONVE	SH ELESCENT
the style of		17. Father's Name (First, Middle, Last)						s Name (First, Middle	, Maiden Surname	
2121 uld be fil Mental I marked	Be	BENNIE BLANDING	as Drint \		10h Mailing	Address (Stra		PHNE HAMIL		un State Zin Code)
MD 21 ad 2 should lith and Me m 27 is ma aumatic ev	ပ	19a. Informant's Name/Relationship (Ty		19	_	•			•	Maryland 2121
- p = a = a		Gloria D. Burton/ 20a Method of Disposition		20b. Plac		ition (Name of ce		Date Date		- City or Town, State
Page ent		1 X Burial 2 Cremation 3 Dogation 5 Other Specify:	Removal from St	aic	-	EMORIAP	PRK	10-13-06	BALTIMO	ORE, MARYLAND
Baltimore, permit. Pages I at Department of Hei Important: If ite		21. Service License	ee		W.	ame and Addres	: BROM	IN COMMONT	TY FUNER	AL HOME P.A.
Physician	2 13	3a. Part I. Enter the disease, or compil		the death. Do	not enter th	206 W NO ne mode of dying	)RTH A	VENUE ardiac or respiratory a	rrest, shock, or hea	art Approximate Interval
/Medical Examiner	1	failure. List only one cause on each immediate Cause (Final disease a.)	h line. <b>/</b> lultiple Gunsh	ot Wounds						Between Onset and Death
_xaitiiilei		b	ue to (or as a cons	equence of):						
	iner	if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a cons	equence of):						
ed ssit	xam	events resulting in death) Last	ue to (or as a cons	equence of):			-	<u>., _=-</u> .	•••	
freate be executed g physician and the burial - transit	an/Medical Examiner	dd	AMENDED			<del></del>				
68760, ertificate be ding physicie	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnar		tal death 3	Estania	pregnancy	23d Date of Month	f delivery Day Year
<b>8</b> = 8	iciar	past 12 months?		time of death	=	tal death 3 her (Specify)	Eccopic	, pregnancy	Wichian	Day Teal
Box he death of the atternance by the atternance hed for us	Physici	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown	h but not resu	ilting in the i	inderlying cause	given in Pa	et I 23e. Did	tobacco use contr	ribute to the cause of death?
P.O S that the general broader and the detaction	by F	Part II. Other significant conditions	contributing to deal	in but not resu	inting in the c	indonying daddo	givoiriiria		'es 2 No 3	
rds, require been si	letec							24a. Wa		Were autopsy findings available prior to completion of cause of
eco he law ate has	Completed by						W W W.		formed?	death? ✓ Yes 2 No
ian: T certific ctor, p	Be C	25. Was case referred to medical examiner?	ospital:					(Check only one)		
F Vit Physic or this	To F	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ent 2 🗸 EF	R/Outpatient	lancoura!	Other <sub>4</sub>	Nursing Home 5	Residence 6	Other:
Division of Vital Records, P.O ral or Attending Physician: The law requires that it and redeath all Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detac	ion:	1 Natural 5 Pending	Oct 9, 2006	Year) 2	005 hrs		Yes 2	Subject st	not in vehicle	Cu
ivisior  I or Attend after death Director:	ficat	2 Accident Investigation 3 Suicide 6 Could not to	28e Place of I	njury - At hom	e, farm, stree	et, factory, office	building, et	c. 28f. Location or Town		per or Rural Route Number, City
Div Spital o nours af neral D	Certification:	4 V Homicide determined	1-4-1-97					4000 Lewi	ston Avenue,	Baltimore, MD
Division of Vital Records, P.O. Box 68760, vitin 19 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		On the basis of exa	amination and				ace, and due to the ca curred at the time, da		
To To Corr	Me	29b. Signature and title of certifier	and manner stated			29c. Licer	nse number		29d Date sign	ned (Month, Day, Year)
		Theodore H.	Kiel TR.	nue	NI	0.0	.M.E.		October 10	), 2006
3		30. Name and address of person who control Theodore M. King, Jr., MD				111 Penn S	treet, Ba	ltimore, MD 212	01	
S	tate	141 4 1 / / 1	32. Registra	ar's Signature	SAN SAN	and I			-	
Regis	પાદા	49 49 4 4	19 1000	A comme the same	07					

State of Maryland / Department of Health and Mental Hygiene 32752 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shirley Naomi Brodowski 8:00 p M Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3192 Main St. Carroll Manchester If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funéral 1 M 2 F 64 215-40-2195 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No laryland Carroll Director Manchester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3192 Main St. 21102 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Affried Forces! 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Suburban Propane 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond Leroy Ensor Mildred Naomi Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2836 Westminster St. Manchester, Md. 21102 Raymond Lamar Ensor - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal Irom State Middletown Cem. Oct. 18,2006 4 □ Donation 5 □ Other (Specify) Parkton, Ild. 21. Signature of Funeral Service Licensee Eckharot Funeral 3296 Charmil Dr. Chapel P.A. Manchester, Md. 21102 Charmil State Eller Dr. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on past lines. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 menths? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ certificate has been signi rector, page 2 should be 2 🖪 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an autopsy performed 1 🗌 Yes 2 No Be ( 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Inpatient ٩ 1 Yes 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Mannyr of Death 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person no completed cause of death (Item 23a) (Type, Print) St. Westminster South Center Klute lavio egistrar's Signature 31. Date liled (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 32753 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** Steliana Brasoveanu October 13, 2006 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🖾 F 113-70-6591 Director 91 02-01-1915 Romania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 Virginia Avenue 21225 or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: à If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stefan Popescu unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Mr. Dan Brasoveanu / son 4603 Virginia Avenue; Brooklyn, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
eny injury or oth 5 ☐ Other (Specify) ° 4. ☐ Bonation Gate of Heaven Cem. 10-17-2006 Silver Spring, MD 22. Name and Address of Facility Singleton Funeral Home, PA ral Service 0136 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician archao /Medical Examiner ILLR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner burial-transit Develi death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medlcal the IF FEMALE: esr. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? certificate 20 No 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 🗌 Yes this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funerei 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2. and manner stated. 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	. — .		For State Registrar	State of	f Marylan	d / Depa		of He	ealth a	nd M	ental Hy	Rag. No.		32	754
	Physicia	ın	1. Decedent's Name (First, Middle,								Date of De Month	Day	Year		of Death
	/Medica	al .	Robert Ira Burge  4a. Facility Name (If not institution, c		nhor)		45 Ciby T	ouer or l	Localion of		octobe		200 County of De	-	DA.M.
	Examine	=	Baltimore Washin			nter			Burni					runde]	
	Funeral			Sex	7. Age (In yrs.		If Under 1	Year	If Under 2		8. Date of Bir			rthplace (State	
	Director		322-18-7366	1 🖾 M 2□ F	87	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 10-03-	-1919		I	
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c, Cit	y, Town or Lo	cation	·						10d Inside	City Limits
	Maryla f sho	5		Arunde1		en Bur									es 212 No
	death with the Maryland ms 23a or 28a-f show r nust be notified at	Completed by Funeral Director	10e. Street and Number	ALunder	GI	en bur	10f. Zip (	Code				10g. Citize	on of What C	country?	
٠	h with	<u>a</u>	706 Mayo Road				210	61				U.	S.A.		
55	ems a	ner	11. Marital Status	12. Was Dece Armed For	ident Ever in U.	.S. 13.	Was Decede	nt of His	spanic Orig	in? (Spe	cify Yes or No Rican, etc.)	)- 10	Race - Am Black, Wh	erican Indian	
2 10	hours after tural', or the	Y.	1 Never Married 2 Married	1 ⊠Yes If Yes, Giv	2 ∏No e		1 ☐ Yes 2				,			white	
ろいん 21215-0036	hours tural	g pa	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's	Year or Da	ates:	16a Dece	dent's Usual	Occupat	tion			16b Kin	d of Busines	s/lodusto.	
4 5	in 72 n "nat	plet	(Specify only highest	rade completed)	45.3	(Give	kind of work DO NOT use	done du retired)	uring most	of workin	ng	TOD. Kan	1 01 00311163	windustry	
3 2	d with	E O	Elementary/Secondary (0-12)	College (1 2	-40r 5+)	Maj	or					U	.S. Aı	my	
	프프릿토	Be	17. Father's Name (First, Middle, La	st)							(First, Middle	, Maiden S	umame)		-
.⟨⟨√⟩ Maryland	2 should be and Mental is marked or reumetic even	٥	Cecel C. Burges								Meng1				
Aar A	and Marie mari		19a. Informant's Name/Relationship		son /						Route Numb			Zip Code)	
	1 and Health em 27 ther ti	1	Mr. Lawrence Mat  20a. Method of Disposition	thews Bui							rnie, l			r Town, State	
PDSE Itimore, I	Pages nent of I int: if Its iry or o		1 Surial 2 Cremation 3		State	Place of Dispo			1 .	-	-2006				
P.D.& E. Baltimore,	artme ortani Injury		4 Donation 5 Other (Spe 21. ignature if Funeral Service Lit		rar.	yland '			4		-2000 ngleto				PA
Ba	Depa Impo eny l		A book now !!	Mel.	MUIS						en Bur				
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ca	aused the death									Approxir Interval	nate
	Physician	1	Immediate Cause (Final disease or condition		ETAB	OLIC	EN	E-P	HAL	opar	THU			Onset ar	nd Death
	/Medical		resulting in death)	Due to (	or as a conseq	uence of): .			• • • •						
	Examiner		Sequentially list conditions.	D	ENAL		JUNE								
	ed sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):									
_	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):								-	
760,		calE		d		,									
687	ificate g phy: as the	_		0.								T.			
ŏ	leath certificat attending phy I for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pre	anancu				23	d. Date of d	alivery	
B	deat ed for	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Other (spe						Month	Day	Year
P.O.	at the	ج چ	9 Unknown								00 D:41	-			4.1.10
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica r death.  sctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	d by	Part II. Other significant conditions  RECENT MI	VOCHO				use giver	n in Part I.		23e. Did t		•	o the cause of robably 4	
Ö	s been si	Completed	MULTIPLE	STRO	KES						24a. Was		24b. Were a	utopsy findin completion o	gs available
æ	The la	mo									autoj perfo 1 ☐ Yes	ormed? 2 No	death?	s 2 No	or cause or
ital	sician: The law s certificate has t lirector, page 2 s	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	-/-			
>	hysic his ce	٥	1 ☐ Yes 2 No			ER/Outpatien			4 🗀 Nur	sing Hom	ne 5□Resi	dence 6	□Other (Sp	ecify)	
u c	ing P	ö	27. Magner of Death  1 Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury		c. Injury Work			8d. Describe	how injury	occurred		
isic	death death stor: /	cat	2 Accident investigat 3 Suicide 6 Could not	be Oce Bless	of Injury - At ho	om a farm at	M .		es 2 N		8f. Location (	Ctroat and	Alumbarari	Pure / Courte A	umba s
Σ	or afte	Certification	4 ☐ Homicide determine	ed 289. Flace buildir	ng, etc. (Specify	y)	eet, ractory,	опісе			City or To	wn, State)	IVUINDET OF F	iurai Aodie iv	umber.
3	Hospi 24 hour Funer stely fill	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the aminar: On the ba	asis of examina	wiedge, death tion and/or in	occurred a vestigation, i	t the time n my opi	e, date and inion, death	l place, a	nd due to the	cause(s) a date and p	nd manner a lace, and du	s stated. e to the caus	e(s)
79)	within To the	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mor	ith, Day, Year	•)
T	of		A Start		h/u	O	7	4	397-	7		Octob	21	201	6
	10		30. Name and address of parson wh	o completed caus	e of death (Item	23a) (Type,	Print)	۸.		-	,	-1-00			
سين ا	(		Moken Quetim	7 301	Hospi	120 DO	we,	ble	n Be	wn	e, n	w.	2106	71.	
	Stat Registra		31. Date filed (Month, Day, Year) (CT 1 7	2006	egistrar's Signa	H A	anti)								
				W. 17. 200	P. Carlotte Sales	- Par 80	me. Burken								

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 083.5 AM ANDREW OC TUBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MODICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 3 9. Birthplace (State or Foreign Country) Greece Sex X M 2□F 7. Age (In yrs. last birthday) **Funeral** Days Hours 73 Yrs Director 217-62-1419 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and if item 27 is marked other then "neturel", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or iteme 23s or 28s-f show the Medical Exeminer must be notified at 1 Yes 2 No Baltimore City MD Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 506 Rappolla St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mechanical Elementary/Secondary (0-12) College (1-4or 5+) Engineering Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodora Mamalis Anthansios Blicas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Rappolla St., Baltimore, MD 21224 19a. Informant's Name/Relationship (Type, Print) Irene Blicas - Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if eny injury or once. Oak Lawn Cemetery 10-18-2006 Baltimore, MD 21. Signature of Pulleral Service License 22. Name and Address of Facility Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMO RRHAGE **Physician** INTRA CRANIAL 3 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a. Certifie Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-ØØØ OCTUBER 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSTROW MD PHD 4940 EASTERN AVENUE BALTIMORE MIRTUAD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 1 7 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 32756 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October Physician Douglas 2006 Heath Center 16 06:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 102 Disney Avenue Pasadena Anne Arundel | FdSdUctru
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Sept. 09 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 217-16-4426 85 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or iteme 23a or 28a-f ehow vent, the Medical Examinat must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Disney Avenue 21122 USA by Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Repairman Montgomery Ward ulth and Mental Hygid 27 le marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irene ဂ္ В. Center Wharran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 (spouse) Ruth Center 102 Disney Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Cedar Hill Cemetery 4 ☐Donation 5 ☐ Other (Specify) 2006 Brooklyn, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1/Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exam that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Qunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes t irector, page 2 s autopsy 1 ☐ Yes 1 Tes 2 No 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and a ress of erson who completed cause of death (Item 23a) (Type, Print) Sw alin Burnie MD 21061 Dalle filed (Month, Day, Year) State Registrar 2006

			1 - For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of F	lealth and <i>Death</i>	Mental Hyg	iene 200	6 32757
E	Physici		1. Decedent's Name (First, Middle, Last) Paul A. Cardillio				***	2. Date of Deat Month October	h Day Ye	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give services 814 Hidden Bluff	street and number)		4b. City, Town, or			4c. County of Baltimo	
	Funeral Director		5. Social Security Number 6. Sep 048-10-2516		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country) Onnecticut
baitimore, maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Baltimor  10e. Street and Number  814 Hidden Bluff  11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced  15. Decedent's Edu  (Specify only highest grade  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Anthony Cardillic  19a. Informant's Name/Relationship (Ty,  Maria Gibson/daugl  20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 XDonation 5 Other (Specify)  21. Signature of Euneral Service License Ronald S.	Circle  12. Was Decedent Ever in Armed Forces?  1 V Yes 2 No If Yes, Give Year or Dates: Was cation a completed)  College (1-4or 5+)  4  chio  pe, Print)  hter	19b. Mailin 814 I	Ville  10f. Zip Code  10f. Zip Code  10f. Zip Code  11	specify:  ation during most of with the state of Facility  as of Facility  Tomy  Board  Specify:  ation  18. Mother's Na  Elizal  and Number or F  uff Circ  e)  Long  Tomy  Board  Specify:  Specify:  And Supplies the state of Facility  Tomy  Board  Specify:  Specify:  And Supplies the state of Facility  Tomy  Board  Specify:  Specify:  And Supplies the state of Facility  Tomy  Board  Specify:  Specify:  And Supplies the state of Facility  Tomy  Board  Specify:  Specify:  And And Specify:  And And And And And And And And And And	Specify Yes or No- rto Rican, etc.)  orking  ame (First, Middle, Noeth Flami flural Route Number, cle Catons Date	Black, N Specify:  16b. Kind of Busin  Maiden Surname)  LO City or Town, Sta  SVI11e, M 20c. Location · City	A American Indian, White, etc.  white ess/Industry unk  te, Zip Code) ID 21228
,0070	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Alter this certificate has been signed by the attending physicien and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit on burial-transit.	Completed by Physician/Medical Examiner	23a Part1. Enter the disease, or complete hock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to mine distance cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consider to form to fo	equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy Other (specify)	ANCE	R	23d. Date of Month acco use contribut s 2 Li No 3 C	Day Year  te to the cause of death?  Probably 4Unknown  a autopsy findings available to completion of cause of h?
on or vital	tending Physicien: The lav leath. tor: After this certificate has the funeral director. page 2	To Be	27. Manner of Death  1 22Natural 5 Pending	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at ?	ath Check only one Home 5 PResider 28d. Describe how	nce 6 Other (S	Yes 2□ No Specify)
	ei or Attend s after death f Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre		∕es 2 □ No	28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,
	To the Hospitei or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Clack only one) 1 Certifying Phys	ician: To the best of my kiler. On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and plac einion, death occ	e, and due to the cau urred at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
	Tott Tott comp	Me	29b. Signature and title of certifier  MULLIANT SAN  30. Name and Alless of person who con	4 MD	om 22-) (7	29c. License		1	d. Date signed (M Detoduc	ionth, Day, Year) 12, 206 10-21236
	Sta	te	C VERBARA - G &  31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 💉	KUN SA	WARE DR	- BALTIN	MERE, F	40.21236
	Registr		OCT 1 7 200	6	J. Apr	WELL.				

State of Maryland / Department of Health and Mental Hygiene 2006 32758 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ronald E. Carroll October 15 2006 6:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1103 Fuselage Avenue 7. Age (In yrs. last birthday)
56 Yrs. Sept 20 1950 Middle River Baltimore 5. Social Security Number Birthplace (State or Foreign Country)
 VA **Funeral** 1 M 2 □ F 216-56-8152 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 Fuselage Avenue 21220 U.S.A. Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Cutter Aerospace 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Menta! Russell E. Carroll Catherine Bomar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Blevins Sister 30 Longeron Drive Baltimore, MD 21220 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Deportment of H
Important: If Ite
any njury or ott cometery, crematory or other place Holly Hill Cem. W Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/06 White Marsh, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Address of Facility 300 Mace Ave Baltimore, MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician<sup>\*</sup> Cancor disease or condition resulting in death) ears -una /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sunsequence of): Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2.XNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0057644 10/15/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) evino MD B2N 235 4940 Eastern Ave Baltime MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

TOURISM CONTROL STATES CARLYON  COLDEN TAKES	Glenn James Ca	1	- For State	tate of Ma	ryland /	-	tment of		and	Menta	al Hyg			20	06	3275
Service Security Amend Crief Transport (1988)  6. Security Amend Crief T		n/	Decedent's Name (First, Midd		mon.				-			Date of Dea	ath			. Time of Death
Second Security Number   Country   C								4b. City, Tow	n, or Lo	cation of		October			Death	
21 4 - 80 - 77 95   IXM   Sign   Balt Timore			618 West Franklin St	reet Apt 1				Baltimo	re					N/F	ł.	
214 = 80 - 7795   134   15   15   15   15   15   15   15   1			5. Social Security Number			(In yrs las	st birthday)		$\overline{}$			8. Date of B	rth(MM/DI		Foreign	
Tas State   St	Director	ļ		1 X M 2	F		38 Yrs		54,0	1100.0		11/03	/196	7	Count	try) MARYLAND
The control of the	any	ł				10c. City, T	own or Locat	ion					-		1	Od. Inside City Limits
Secretary to the date of the control of the contr	*	اۃ	MARYLAND N	I/A			BALT	IMORE							1	Yes 2 No
Secretary to the date of the control of the contr	Maryla		10e. Street and Number					10f. Zip Co	de				10g. Citize	n of What	Country	y?
Secretary to the date of the control of the contr	ith the					- : U.O	140 97				2 / 2					
Physician Medical Sammer of Death	ath w	ner		Married Arm	ned Forces?_		. 13. VVa	es, specify C	of Hispa uban, M	nic Origin Iexican, P	r? (Spec Puerto Ri	can, etc.)	o-   1			n Indian, Black,
Physician Medical Sammer of Death	ifter de	ᄔᅵ	3 Widowed 4 Di	vorced If Yes, Gir		XX No	1	Yes 2 X	No s	specify:			S	pecify: F	3LAC	K
Physician Medical Sammer of Death	hours a			ecify only highes									16b. Kir	d of Busir	ness/Ind	ustry
Physician Medical Sammer of Death	36 iin 72   iin 74   iin 72	Bet		Colle	ege (1-4 or 5	+)			<b>J</b>			•				
Physician Medical Sammer of Death	d with square of with ygiene other t	탉	unknown 17. Father's Name (First, Middle	, Last)	····			N/A	18.	.Mother's	Name (F	irst, Middle,				
Physician Medical Sammer of Death	1215 I be fill ental H rrked	8								LII	LIE	MAE C	ARLTO	ON		
Physician Medical Sammer of Death	D 2 should and M 7 is m	위			t)		1									
Physician Medical Sammer of Death	e, M l and 2 Health item 2	ŀ	20a. Method of Disposition				ace of Dispos	ition (Name o	ewoo of cemer	tery,						
Physician Medical Sammer of Death	mor ages l ent of l nt: If	-			val from Stat	· ·			т.		10-1	17-06	BAT.7	птм∩п	ा जर	ΜΑΡΥΤ.ΑΝΠ
Physician Medical Sammer of Death	alti mit. epartm nporta jury o	ı		Licensee			22. N	lame and Add	dress of	Facility						
### Failure List only one cause on each line.    The property of the property		4	OM DAJA C	. 0		ha daath I	112	06 W N	ORTH	I AVE	INUE	_				
The state of the s		Į	failure. List only one cause	e on each line.				ie mode or d	yirig, su	CII as Cali	ulac or re	espiratory an	rest, snock	i, or neart		Between Onset and
The state of the s	xaminer														$\pm$	
The composition of the composi	model	ايز		b. Due to (o	r as a conse	quence of):								_	_	
The composition of the composi		إ	cause. Enter Underlying Cause (Disease or injury that initiated	c								_				
UNPENDED   AMENDED   AMENDED   AMENDED   AMENDED   AMENDED   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d	cuted and transit	Ä	events resulting in death) Last		r as a consec	quence or).	•									
So you was decedent pregnant in the past 12 months?    Company   C	be es brian	edica	UNPENDED	AMEN	DED							_				
The state of the contributing to death but not resulting in the underlying cause given in Part 1.    25	876 rtificate ing phy as the		3b. Was decedent pregnant in t	he -		e of pregna		tal death	3	Ectopic p	regnanc	y				Year
The state of the contributing to death but not resulting in the underlying cause given in Part 1.    25	OX 6 sath cer attend	Sici		denous		ime of dea	th 5 Ot	her (Specify)					l			
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	D. B t the de by the	-	Part II. Other significant condi			but not res	sulting in the u	inderlying cal	use give	en in Part	l.	23e. Did t	obacco us	e contribu	ute to the	cause of death?
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ires that signed										_	1 Ye	s 2 🗸	No 3	Probab	ly 4 Unknown
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ords w requ	Bete									_					
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	Reco	Ĕ														2 No
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ician:								Ott	bor:						
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	of V g Phys fter thi	⊢ŀ		28a	Date of Injur	y					<u> </u>					cene 
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ion (tendin eath or: A:	틽		ulig	Month Day Ye 112, 2006	ar)	2145 hrs	1	Yes	2 🗸 N	。 Sι	ubject sho	ot			
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ivis or At after d Direct	<u>≅</u>	3 Suicide 6 Cou	ld not be 28e.	-			et, factory, off	ice buile	ding, etc.		or Town. S	State)			
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	ospital hours nneral		4 M Homicide 29a. Certifier	(0,0)			_					8 West F	ranklin			
29b. Signature and title of certifier  O.C.M.E.  October 13, 2006  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature	the H thin 24 the Fi	dica	(Check only Certifying F	aminer: On the b	asis of exam											
30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year) 32 Registrar's Signature	F 3 F 8	<b>≗</b>	29b. Signature and title of certific		M	A /		29c. Li	cense n	umber			29d. Da	te signed	(Month	, Day, Year)
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 2006 32 Registrar's Signature			Mhsia B	rasse	Wh	18		0	.C.M.	E.			Octob	er 13, 2	2006	
State 31. Date filed (Month, Day Year) 2006 32 Registrar's Signature	4		· ·			,	′	enn Stree	t, Bal	timore,	MD 21	201				
		ite rar	31. Date filed (Month, Day, Year	2006			Logo	de?								

	Registrar  1. Decedent's Name (First, Middle, Last		- Cortinoato C	n Deam	2. Date of Death Month	Day Year	32760
sician edical		CUSTIS			October	10, 2006	9:23 p
miner	4a. Facility Name (If not institution, give	·		n, or Location of Dea	th	4c. County of Death	9
ral	Laurel Regional Ho		Laure (ast birthday) If Under 1 Ye	ar If Under 24 Hrs		Prince G	eorge's place (State or Foreig intry)
ai or		M 2□F 71	Yrs. Months Da	ys Hours Min	June 16,		<sub>intry)</sub> nnsylvania
	Usual Residence of Decedent	140-00					
5	10a. State 10b. County		, Town or Location				10d. Inside City Limi
ecto	MD Prince (	eorge's La	urel 10f. Zip Coo	•	100	. Citizen of What Cou	
ă	15613 Bradford Dr	ve	2070			.S.A.	y:
Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S		of Hispanic Origin? (S Suban, Mexican, Puer		14. Race - Ameri	
by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 XIXes 2 □ No 1953 If Yes, Give Year or Dates: 1973	3- 1 ☐ Yes 2 <b>X</b> X		to Hican, etc.)	Specify: B	, etc. lack
Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's Usual Oc	cupation	16i	o. Kind of Business/Ir	•
nple	Elementary/Secondary (0-12)	College (1-4or 5+)		ne during most of wo tired)		Depart	
Co	47 Fabrus Name (First Middle Look)	5 +	Residential	T			Services
Be	17. Father's Name (First, Middle, Last) Russell Custis				me <i>(First, Middle, M</i> ai tt Chandle		
2	19a, informant's Name/Relationship (T)	voe Print)	19b. Mailing Address (Str				n Codel
To Be Completed by Funeral Director	Janice Custis /	wife	15613 Bradfo		Laurel, M		20707
	20a. Method of Disposition	20b. Pla	ace of Disposition (Name or metery, crematory or other	T	The second secon	c. Location · City or T	
	1X Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ington Natior	1	1/6/2006	Arlington	. VA
ė	21. Signature of Funeral Service Licens		-		Home, P.A		111
a	1 GZ Sta	M007			e Laurel,		20707
14	23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death.	Do not enter the mode of	dying, such as cardia	c or respiratory arrest		Approximate Interval Between
	Immediate Cause (Final disease or condition	Pulmonary E	7ibrosis				Onset and Death
	resulting in death)	Due to (or as a consequent					
_	Sequentially list conditions.	Cardiomyopa					
lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequ	anda of).				
Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
		4					
edicai		y				1	
Iclan/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan		1001		23d. Date of deliv	rery
sicla	in the past 12 months? 1 □ Yes 2 □ No	1 ∐Live birth 2 ☐ Fetal ( 4 ☐ Pregnant at time of de: 9 ☐ Unknown				Month	Day Year
Physi	9 Unknown						
by	rait ii. Other significant conditions to	•	, , ,	given in Part I.		co use contribute to	
ted	Chronic Obstruct	ive Pulmonary	Disease		1 Yes	2□No ¾¬Pro	bably 4 Unknov
Completed	Pneumothorax				24a. Was an autopsy	prior to co	opsy findings availab empletion of cause of
Ç					performed 1 ☐ Yes 200		2 <b>X</b> X10
Be	25. Was case referred to medical examiner?	lospital:		Other	ath Check only one)		
P	1 ☐ Yes 2XX\0  27. Manner of Death	XIXInpatient 2 L	Produpatient 3 DOA		Home 5 ☐ Residenc		fy)
tlon	1XX atural 5 ☐ Pending	(Month, Day Year)		njury at Work? □ Yes 2 □ No	20d. Describe flow	inqui y occurred	
fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor			28f. Location (Stree	t and Number or Rur	al Route Number.
	4  Homicide determined	building, etc. (Specify)	•		City or Town, S	itate)	
Fr	29a. Certifier Certifying Phy	sician: To the best of my know ner: On the basis of examination	on and/or investigation, in n	ny opinion, death occ	urred at the time, date	and place, and due t	o the cause(s)
dical Certification;	(Check only 2 Medical Exami						
Medical Certl	(Check only 2 Medical Exami	TATEMON	TCT 29c Lie	ense number	29d.	Date signed (Month,	Day, Year)
edical	(Check only 2 Medical Exami	INTENSV.	IST 29c Lio	00605	63 00	Tober,	Day, Year) 10, 2006
edical	(Check only 2 Medical Exami	TNTENSV.	29c Lic 2 29c Lic 29c Lic 2 2 2 2 2 2 2 2 2 2	HAMME	63 00 D ALAT	TOBER,	Day, Year) 10, 2006 ECU

			1 - For State Registrer	State of Maryland		irtment of I tificate of			giene Reg. No. 0 (	)6	32761
	Physici		Decedent's Name (First, Middle, Last)	Una E. Connell				2. Date of De Month October	ath Day 2006	Year	3. Time of Death  1:21 P <sup>M</sup>
ŀ	/Medic Examin		4a. Facility Name (If not institution, give s Shady Grove Advent	treet and number)		•	or Location of Dea		4c. County of	of Death	
	Funeral Director		Social Security Number 6. Sex		ist birthday) Yrs.	If Under 1 Year Months Days					lace (State or Foreign try)
the Maryland	28a-f ehow	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomer  10e. Street and Number		Town or Lo	Gaithers	sburg		10g. Citizen of W		0d. Inside City Limits 1 X Yes 2 ☐ No
be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if Item 23a or 28a-f show important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give	- 1	20	877 Hispanic Origin? (San, Mexican, Puel	Specify Yes or No to Rican, etc.)	United	Sta - Americ k, White, o	tes an Indian,
within 72 hours	iene. r then "nature!' the Medical Ex	Completed by	3 ☑ Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bu Montgom Gover	siness/Inc	dustry County
uid be filed	Mental Hyg arked other stic event,	To Be C	17. Father's Name (First, Middle, Last) William F. Dillard	d				me (First, Middle, na Bridg	Maiden Sumame es	9)	
end 2 should	salth and in 27 ie ma		19a. Informant's Name/Relationship (Ty)  John D. Connell/So	on	200 C	hapel Ct	and Number or R		ille, Mar	ylar	d 21793
Pages 1	ment of He ant: if iten ury or oth		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	BITTOVAL ITOTIL STATE		sition (Name of natory or other pla lemorial	10000	ober 7, 06	Rockvill		
	Depart import any inj once.		21. Signature of Funeral Service Libense  1. Signature of Funeral Service Libense  23a. Part 1. Entre disease, or complete of the disease, or complete of the part failures.	MO130	)5 RC 3C	Name and Address  Dert A.  O West Mo	Pumphrey			52	
	nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Arrhythmia  Due to (or as a conseque				oooop.iiatoiy a			Interval Between Onset and Death
ate be executed	physicien and is the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque							
The law requires that the death certificate be executed	been signed by the attending p should be detached for use es t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan  1  Live birth 2 Fetal of  4 Pregnant at time of deal  9 Unknown	death 3	Ectopic pregnanc	у		23d. Date Mon		ry Day Year
ouires that	n signed b uld be deta	þ	Part II. Other significant conditions con	tnbuting to death but not resul	lting in the ur	nderlying cause gr	ven in Part I.			bute to th	e cause of death?
	ete hes bee page 2 sho	Completed				_		24a. Was autop perfo	osy pormed? d	lere autorior to coreath?	osy findings available inpletion of cause of
VILC Ricien:	certific rector,	Be c	25. Was case referred to medical examiner?	ospital:	700		har	ath (Check only o			
To the Hospital or Atlanding Physician:	within 24 hours after death.  To the Funerei Director: After this certificete hes completely filled in by the funeral director, page 2.	ation; To	1 ☐ Yes 2 ፟M No  27. Manner of Death  1 M Natural 5 ☐ Pending 2 ☐ Accident investigation		EVOutpatien 28b. Time of Injury	28c. Inju	4   Nursing		dence 6 Other		//
tal or Atte	rs after des ei Directo ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (: City or Tox	Street and Numbe wn, State)	or Rura	l Route Number,
the Hospi	hin 24 hou the Funei npletely fill	Medicai	(Check only 2 Medical Exemir one)	sician: To the best of my know ner: On the basis of examination and manner stated.	vledge, death on and/or inv	restigation, in my	opinion, death occ	urred at the time,	date and place, a	nd due to	the cause(s)
٩	T W		29b. Signature and title of certifier	1 . mo	)	29c. Licen			29d. Date signed October		
	b		30. Name and address of person who co			Print)		11 11			2000
	Sta	ate	Amit Kalaria, M.D 31. Date filed (Month, Day, Year)	. 9901 Medical	L Cent	er Drive	, Kockvi	lle, Mar	yland 2	0850	
	Regist		OCT 1 7 200	16 December 1	Y A	colles					

DHMH 17 Rev 1/2001

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and Mental F rtificate of Death	Hygiene 006 32762
	1 8 %	ŧ	Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death
	Physici /Medic		Ellsworth I. Coburn, Jr.	10/09	0/2006 Year 9:10 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		2	Summit Park Health	Catonsville	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-48-0314 7. Age (In yrs. last birthday) 7. Age (In yrs. l		Birth Day, Year)  9. Birthplace (State or Foreign Country)
-	Director		Usual Residence of Decedent	04/26	/1947 MD
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	a-1 et	ctor	MD Anne Arundel Hanover		1 Tyes 2X No
	or 28	)ire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	72 hours after death with the Maryland natural', or Iteme 23a or 28e-1 ehow Iteal Examiner must be mailfied at	Funeral Director	7212 Forest Ave.	21076	USA
	er de	une	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Marned 1 Yes 2 No 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: White
5-0036	2 hou	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
215	within 7, ene. than "n	Completed	(Specify only highest grade completed)  (Give life.  Elementary/Secondary (0-12)  College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
2121	filed wit Hygiene ther the	Con		fied Public Accountant	Accounting
pu	be file d offh	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	ldle, Maiden Sumame)
yla	ould Men Parks	2	Ellsworth I. Coburn, SR.	Clara E. Dail	
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailin Ellsworth I. Coburn, Sr / Father 7212	ng Address (Street and Number or Rural Route Nu Forest Ave Hanover	
	1 and Healt em 2	. 1	20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any figury or other traumatic event, the Medical Examinet must be millist at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crei	matory or other place) Memorial Park 10/14/2006	· ·
Ħ	nit. P artme ortan injur e.		21. Signature of Funeral Service Licensee	Name and Address of Facility	
Ä	permit. Departr Imports any inji		M/1/1 Ga:	ry L. Kaufman Funeral H 250 Washington Bivd., E	ome at MMP, INC.
安	7		23a. Part1. Enter the disease, or complications that caused the death. Do not entered by the complete of heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respirator	y arrest, Approximate
120	Physician		Immediate Cause (Final disease or condition	r Yumor - 6/10 bl	ng tour Oaset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):		190
3	Examiner		Sequentially list conditions, b		
7	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury		
V	and and II-tran	хап	that initiated events resulting in death) Last  C		
68760,	icate be executed physicien and s the burial-transit	dical			
68	ificate g phy as the		<u> </u>		
Вох	death certificate b a attending physic d for use as the b	N/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy	23d. Date of delivery
	deat	sicis	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
P.0	that the death cer ed by the attendir detached for use	Physician/Me	9 Onknown		
	Se Log	þ	Part II. Other significant conditions contributing to death but not resulting in the u		id tobacco use contribute to the cause of death?  ☐ Yes 2000 3 ☐ Probably 4 ☐ Unknown
Records,	w requir been si should	Completed			3
<b>3ec</b>	has t	mpi			/as an utopsy are autopsy findings available prior to completion of cause of death?
a	n: Th ficate or, pag	မ ငိ	25. Was case referred to medical	1 □ Ye	s 20 No 1 Yes 2 No
Vital	s cert	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check on other: 42 Nursing Home 5 R	ly one) esidence 6 □Other (Specify)
of	g Phy er this		27. Manner of Death 28a. Date of Injury 28b. Time of		be how injury occurred
io	ath. r: Aft	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 ☑ Accident Investigation	M 1 Yes 2 No	
Division	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Locatio City or	n (Street and Number or Rural Route Number, Town, State)
	ital o				
	To the Hospital or Attending Physician: The I withing 4 withing 4 mours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only 2D Medical Examinar: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to t vestigation, in my opinion, death occurred at the tin	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	- 3 - 8			14-9719	10/12/01
	00		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	(0/12/06
	M		Marcelinó D. Albuerne, M.D., 516 N. R	•	Catonsville, MD 21228
	Sta	- 1	31. Date filed (Month, Day, Year) 32. Segistrar's Signature		, == =====
-16 0	Registr	ar	OCT 1 7 2006 Dece &	sec .	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 32763 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and gutnber) City, Town, or Location of Death Examiner If Under 1 Year Months D~ 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 213-2658-38 776 Yrs. Director Jan 15 1930 rewe Usual Residence of Decedent the Maryland 10a. State 10b. County ta or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Baltimore CO Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Mickett 21236 12. Was Decedent Ever in U.S. Armed Forces?

1 Sayes 2 1 No 18 Yes, Give 20 Jul 49 Year or Dates: 14 Nov 4 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No à Specify: Black 3 Widowed 4 Divorced 14 NOV 49 "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than traumatic event, If e M. Elementary/Secondary (0-12) College (1-4or 5+) Driver for Armoo Steel 12yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) trank Carter Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Hickory Baltimore arter (Wife) Annie ). Q Thickett of Health ace ortant: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State comotory, cromatory or other place)
Garrison Forest
Vereran Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delle, 2006 DWing Mills 21. Signature of Funeral Service License 22. Name and Address of Facility TRI-State Funeral Services 5732 Georgia Ave. NW. 20011 Washington DC. 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequen **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached of Vital Records, P.O. 9 Unknown a ntributing y death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 🗌 Yes 1 Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation s after dea. cal Diractor: Aftr 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 1018106 pleted cause of death stem 23a) (Type Print) Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ificate of	Death			Reg. No.	200	6 3276
Physicia	an/	Decedent's Name (First, Middle,Last						2. Date of De Month October		Year	3. Time of Death 2153 hrs
edical Exami	ner	SHARON DAN  4a. Facility Name (if not institution, give			<del>- L</del>	b. City, Town, or	Location o			ounty of Death	2155 1115
		St. Agnes Hospital	street and number)		1	Baltimore	Location o	Deall	40. 0	N/A	
Funeral		Social Security Number 6. Se	7. Age (	In yrs. las	t birthday)	If Under 1 Yea	r If Under	r 24Hrs. 8. Date of E	lirth( <b>MM</b> /DD	)/YYYY) 9. Birtl	
Director		218-78-1910	M 2XF		4.4 Yrs.	Months Day	s Hours	Min. 03 /04	/1962	Foreign Cou	n <sup>Intry)</sup> MARYLAND
	ŀ	Usual Residence of Decedent			44			01/04	/ 1502		
v any	ſ	10a. State 10b. County	10	Oc. City, T	own or Location	n	-	_			10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	MARYLAND N/A			BALTI.						1 X Yes 2 No
ie Maryland or 28a-f sho fied at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Coun	try?
th the 23a or notifi		5115 ARBUTUS A				21215				S.A.	
ath wi	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Example Armed Forces?	_				in? ( Specify Yes or N Puerto Rican, etc.)	10- 14	White, etc.	can Indian, Black,
ter de ", or i			1 Yes 2 3	No	1	Yes 2 X X No	specify:		Sp	ecify: BLA	.CK
tural amin	d by	15. Decedent's Education (Specify or	or Dates: y highest grade compl	eted) 1	6a. Decedent	s Usual Occupat	tion (Give k	ind of work done	16b. Kind	d of Business/Ir	ndustry
5-0036 ed within 72 hours lygiene, other than "natur	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	)		st of working life		use retirea)			
003 vithin iene er thz	Ĕ	10th grade			SALES	ASSOCIA				L-MART	
	a)	17. Father's Name (First, Middle, Last)  JAMES HOWARD						s Name (First, Middle ISCILLA GE		,	
2 5 5 E 9	0 B	19a. Informant's Name/Relationship (T	rpe, Print )		19b. Mailing	Address (Stree		ber or Rural Route Nu			Zip Code)
2022	-	Darwyn Davis/Hus	and		5115	Arbutus	Avenu	ue, Baltim	ore, l	Marylan	d 21215
ore, MD ges 1 and 2 st of Health an : If item 27 i		20a. Method of Disposition  1 XX Burial 2 Cremation 3	Bemarial from State		ace of Disposi ematory or oth	ion (Name of cei er place)	metery,	Date	20c. Loc	cation - City or	Fown, State
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specify:	Removal from State		ZION	CEMETERY	Z	10-21-06	LAN	SDOWNE,	MARYLAND
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Service Licens	see	,	22. N	ame and Address	of Facility BROWI	N COMMUNIT	Y FUN	ERAL HO	ME P.A.
		23a. Part l. Enter the disease, or comp		a da a tha F	1.2	06 W NOF	RTH AV	/ENUE			
Physician /Medical		failure. List only one cause on ea	ch line.					ardiac or respiratory a	rrest, shock,	, or near	Approximate Interval Between Onset and Death
Examiner			Hypertensive Due to (or as a consequ			ir disease	2				Dean
)		Sequentially list conditions, b.									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):							
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
ecuted and trans		d									
760, cate be executed physician and the burial - transi	Medical	X UNPENDED	AMENDED #23a,			861,11/2/	06 TT				
	n/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	of pregna		al death 3	Ectopic	pregnancy		Date of delivery onth D	ay <b>Y</b> ear
Sox 687 feath certific e attending I for use as the	/sician/	past 12 months?  1 Yes 2 No 9 ✓ Unknown	4 Pregnant at tir	me of deat	U	er (Specify)					
Box he death of the atten-	Phys	Part II. Other significant conditions	9 Olikilowii		vilting in the i	ndodujna nauno	niuon in Do	+1 23e Did	tobacco uso	o contributo to t	he cause of death?
P.O.	þ	Obesity	contributing to death t	out not res	anning in the di	idenying cause (	given iii i a				ably 4 Unknown
ords,  * require  s been sig	Completed		-					24a. Wa	s an	24b Were aut	opsy findings available
Records,  The law require ficate has been si page 2 should b	nple					-		per	opsy formed?	prior to co death?	ompletion of cause of
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical				26 Blood	of Dooth /	1 Yes	2 No	1 🗸 Ye	s 2 No
'ital sician: is certif irector,	Be	examiner?	ospital: 1 Inpatient	2 🗸 E	R/Outpatient		Othor -	Nursing Home 5	Residence	e 6 Other:	
of Vital ing Physician: After this certi funeral director	-: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	- 12	28b. Time of Ir		ry at Work				
ion ( tendin eath or: A the fur	ıtior	1XX Natural 5 Pending	(Month, Day, Yea	"		1	Yes 2	No			
Division tal or Attendir rs after death al Director: A	ertification:	2 Accident Investigation 3 Suicide 6 Could not	28a Place of Injur	ry - At hon	ne, farm, stree	t, factory, office t	ouilding, etc	28f. Location or Town,		Number or Rur	al Route Number, City
Di spital lours a neral I	Cert	4 Homicide determined	(Specify)								il.
Division of Vital Records, P.O. Box 68  To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death  The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	edical	29a. Certifier 1 Certifying Physici one) 2 Medical Examiner	an: To the best of my l								
To the within To the comp	Medi	29b. Signature and title of certifier	and manner stated.			29c. Licens				te signed (Mon	
	=	hy hi, m				O.C.				er 15, 2006	
	- 5	30. Name and address of person who		ath (Item 2	?3a)						
1	2		edical Examiner	111 F	Penn Stree	t, Baltimore,	MD 212	01			7/
	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Signatur	t Ana	all s					
′ Regis	trar	OCT 1 7 20	المراجعين المراجع المراجع المراجع المراجعين ال	فعاند تحسيا	and the same	مستانية					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ashok Christopher Dassenaike

		I- For State Registrar		Cei	rtifica	ite of	Death				F	Reg. No.	20	100	32	. 100
Physicia		Decedent's Name (First, Midd)	le,Last)								Date of De		Van		Time of De	ath
Medical Exami		Ashok Chris	stopher	Dassen	aik	e					Month October	Day 12, 20	06 Year		1301 hrs	5
		4a. Facility Name (if not institution  Northbound I-95 near		umber)		41	City, Town	n, or Lo	cation of	Death			County o		······································	
<u> </u>	#	Social Security Number	6. Sex	7. Age (In yrs. I	last hirth	day)	If Under 1	Vear	If Under	24Hrs 8	Date of B				lace (State o	or Foreign
Funeral Director		,						Days	Hours	Min				Count	try)	
Director		217-37-0308	1 XM 2 F		24	Yrs.				1 1	/14,	/ 198	32	Sr	i Lar	ıka
>:	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	Town	or Locatio	0							1	0d. Inside Ci	ity Limits
w any	ł		timore			kvi										2 <b>X X</b> No
land f sho	ē	Bui	rimore		Par	KVI.										24240
ie Maryland or 28a-f show fied at once.	Director	10e. Street and Number				ı	10f. Zip Co					10g. Cit	izen of Wha	at Country	(?	
ith the 23a or notifie		9747 Denrob	Ct.				2	2123	34				USA			
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral	11. Marital Status	A	cedent Ever in U	.S.		Decedent of s, specify C					lo-	14. Race - White		n Indian, Bla	ick,
death	Ě	1 X XNever Married 2 M	arried 1 Yes	2XX No		11 10	o, speeny o	aban, n	WOXIOGIT, I	r dono rviol	ari, etc.)				_	
after al", e	J.	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:	ar			Yes 2XX								nales	e
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin		15. Decedent's Education (Spe					s Usual Occ st of working					16b.	Kind of Bus	siness/Ind	ustry	
6 172 h an "r	Completed	Elementary/Secondary (0-12)		1-4 or 5+)						,			lorga			
within sene.	Ĕ	12	4			A	ccour	يملا	nt				Jnive		<u>ty</u>	
215-0036 be filed within 7 antal Hygiene. rked other than		17. Father's Name (First, Middle	Last) Alast	air Chri	stopl	ner A.							Surname)			
21215 uld be file Mental H marked c event, t	a	Alasdair Ch	r <del>istoph</del> e	r Asok			enaik Address (			remi				- 01 1 7		
MD 21 2 should I h and Mer 27 is mar imatic ev	유	19a. Informant's Name/Relations	Bassenajke	•	119		,						•			- 1
두 말씀 티쳤다		20a. Method of Disposition	<del>ssenarke</del>	!			Denr				ate UNK		Location -			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation	n 3 Removalf			ry or othe			,				olom		viii, Otato	
imor Pages ment of tant: If		4 Donation 5 Other S		ונו	nk							l s	ri L	anka	ì	
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service	Licensee			22. Na E <b>V</b> 8	me and Add	dress o	f Facility	Cha	pel	Ę	800	Har	ford	Rd.
	1	Majeto 152	No.			land	d Cre	emat	tion	ı Ser	Vice				e, MÇ	The second second
Physician		23a Part I. Enter the disease, or failure. List only one cause		caused the death	n. Do no	t enter the	e mode of d	ying, st	uch as cai	irdiac or res	spiratory a	rrest, sh	ock, or hea	at .	Approximate Between Or	nset and
/Medical Examiner		Immediate Cause (Final disease	<sub>a.</sub> Head and	neck injuries	3										Deat	th
	- 1	or condition resulting in death)	Due to (or as	a consequence o	of):											
The same of	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	of).									-		
	۱	cause. Enter Underlying Cause		a 00/1004a0/100 0	J1).											
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	of):											
O, e be executed ysician and burial - transit	삚		d	17	£b.	~0 <u>~</u> 0	10-2	<del> Λ</del>	6 <del>111</del>							
(0, e be exe ysician burial	n/Medical	UNPENDED	X AMENDED	#17,19a,	20b,	perFi	10-2 I, 6861	<b>,</b> 11/	17/06	TT						
8760, ifficate bing physicast bunst as the b	18	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg					1			23	d. Date of	•		
68' certiff ading se as	ä	past 12 months?	I LIVE	birth nant at time of de			al death		Ectopic	pregnancy		- 1	Month	Day	/ Y	/ear
Box 687  Re death certific  the attending p	Physicia	1 Yes 2 No 9 Un	known 9 Unkr		5	Otn	er (Specify,	)				(0.57)				
that the dended by the	문	Part II. Other significant condi	tions contributing	to death but not r	resulting	in the ur	nderlying ca	use giv	en in Par	rt I.	23e. Did	tobacco	use contrib	bute to the	e cause of de	eath?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	و										1 🗌 Y	es 2	<b>/</b> No 3	Probat	oly 4 Ur	nknown
ords, w require is been si should b	Completed by	-									24a. Wa	s an	24b. W	Vere auto	psy findings	available
Sore law re has bo	츁											opsy formed?		rior to con eath?	npletion of ca	ause of
tal Rec cian: The certificate	등										1 🗸 Yes	2 1	No 1	<b>✓</b> Yes	2	No
tal Rection: The certificate	Be (	25. Was case referred to medica examiner?	Hospital:							Check only		_		_		
Vity Signature of the s	To I	1 ✓ Yes 2 No		Inpatient 2		tpatient				Nursing H			ence 6 🗸		cene	
J of Jing Ph	Ë	27. Manner of Death  1 Natural 5 Page	28a. Date	e of Injury th Day Year) , 2006	28b. 1 1258	ime of In			at Work?	ln-i			object c			
Sior Attend or death rector: by the	aţi	⊨ ······· 5 □ Pen	estigation						s 2 🗸 1							
ivis or A after Direct	ı <u>ş</u>		ild not be	ce of Injury - At h			t, factory, of	fice bui	ilding, etc.		or Town,	State)			Route Num	ber, City
Spital Dours	Certification:	4 Homicide	ermined (Specify	/ Interstate/	Expre	SS		_		No	rth I-95	near E	Exit 47, F	Relay, N	1D	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		Check only	Physician: To the be aminer:On the basis		-											
To the comp	Medical	2 🔻	and manner			, roongun			number						n, Day, Year)	
	2	29b. Signature and title of certifi	21	·											, Day, rear)	
A		washe	11000	fill.	0			D.C.M					tober 13	, 2006		
4		30. Name and address of person				444	O		) =  4:mr -		1204					
-		Tasha Greenberg MD		Medical Exan		1111	Penn Stre	eet, B	aitimor	re, MD 2	1201					
S Regis	tate trar	31. Date filed (Month, Day, Year,	0000 52.	Registrar's Signat	ture	han	20									
V-14 (-)		1 1 5 7 5 43. 6		production of the second	w h	THE REPORT OF										

				1 - For Sta	ate of Maryland /		nt of Health and te of Death	Mental Hygie	/ 11115	32766
		Physic /Medi		1. Decedent's Name (First, Middle, Last)  Gilbert R.	Della Ja	٤.		2. Date of Death Month October 1	Day Year	3. Time of Death
		Exami		4a. Facility Name (If not institution, give street  Joseph Rytchy  5. Social Security Number  6. Sex	e Hospice 7. Age (In yrs. last t	4b. City	Town, or Location of Dea Bultmore or 1 Year If Under 24 Hrs	th  8. Date of Birth	4c. County of Death	
		Director		Usual Residence of Decedent  10a. State  10b. County		Yrs. Months	Days Hours Min		935	MD
		death with the Maryland ms 23s or 28s-f show rmat ke richitied at	ector	MD. N/A	_	altimore	<del></del>	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1 11 → es 2 1 No
		ath with t	Funeral Director	274 /tighland			p Code V S S I S		Citizen of What Cou	·
	9036	72 hours after de: natural', or Itema licel Examinar m	by	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 14 No Yes, Give ear or Dates:	13. Was Dece If Yes, spe	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 200 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: AFn	
	Maryland 21215-0036	d within 72 h giene. er then "natu i tre Medicel	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12) Co	oleted) 16 billege (1-4or 5+)	-	Ial Occupation ork done during most of wo use retired)	rking 16b	FOOD	ndustry
	yland	should be filed within and Mental Hygiene. s marked other then " numatic event, Ine Me.	To Be C	17. Father's Name (First, Middle, Last)  Gilbert R. Della			18. Mother's Na	me (First, Middle, Maid rganet B	arks dale	i
		1 and 2 Heelth tam 27 i		19a. Informant's Name/Relationship (Type, Pr  Letthornia 3 Cyley  20a. Method of Disposition  1 Dr. Burial 2 □ Cremation 3 □ Remove	Doughter 20b. Place		s (Street and Number or R. Lifton Pank me of other place)	Terrace o		EISIS OM
Om	, Saltimore,	permit. Pages Department of Important: If I any Injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Trib	12. Name al	nd Address of Facility LOSE LOSE LOBEITANE RE	er 19, 2006 1	Baltimore envice,	P. 17.
13		Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.	not enter the mod	de of dying, such as cardia	c or respiratory arrest,	hore mo	Approximate Interval Between Onset and Death
2/06	8760,	/Medical Examiner Assign and purlal-transit	Ilcal Examiner	Saquemally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence  Pros  Due to (or as a consequence  Due to (or as a consequence	e of): e of):	cancen			2 years
10/1	P.O. Box 6		Physician/Medical	in the past 12 months?	res, outcome of pregnancy ]Live birth 2   Fetal deat ]Pregnant at time of death ] Unknown	th 3 □Ectopic p 5 □ Other (sp			23d. Date of deliv Month	ery Day Year
4		sign sign d be	δ	Part II. Other significant conditions contribution	ng to death but not resulting	in the underlying o	cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
Ibert	Vital Records,	iician: The law requ certilicete has been rector, page 2 should	Completed					24a. Was an autopsy performed	? prior to co	opsy findings available ompletion of cause of
(h		Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	: 1	200	Other	ath (Check only one)		A.c.
	ion of	ding After fune	atlon; To			Time of Injury M	DA 4 Nursing F 28c. Injury at Work? 1 Yes 2 No	forme 5 Residence 28d. Describe how in		m) Hospice
ella	Division	Hospital or Attendi 24 hours after death Funaral Director: A tely filled in by the t	Certification;	4   Homicide	Place of Injury - At home, f building, etc. (Specify)			City or Town, St.		
Å		To the Hospital or within 24 hours after to the Funaral Dir connetely filled in	Medical	one)	To the best of my knowledge in the basis of examination a dimanner stated.	ge, death occurred novor investigation	at the time, date and place , in my opinion, death occu	, and due to the cause irred at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
		o s	2	29b. Signature as title of certifier	> PHISCORN		C. License number		Date signed (Month,	, .
	_ 	1		30. Name and address of person who complete	od cause of death (Item 23a)		N. edmer.	1 SF #310	BALDOWN	a mornou
		Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Book				,

			For State Registrar			State o	f Mary	/land /	Depa Cert	rtmer tifica	nt of H e of L	lealth a Death	and M		Reg. No		16	3276	7
	Physicia	an	Decedent's Name											2. Date of Dea Month	Da	y Y	ear	3. Time of Death	
	/Medic	al	James A11				mher)			4h City	Town or	Location		October		. County of	Death	7:15 AM	
	Examin	ier	414 Bal				•			4b. Oity		mins			10		rro	11	
	Funeral		5. Social Security N		6. Sex			n yrs. last t	birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birt	h Van ri	9	. Birthp	ace (State or Fore	ign
	Director		213-01-95		1 <del>1</del> ₹ M	2 🗆 F	9	91	Yrs.	Months	Days	Hours	Min.	Month, Day May 12,	19	15 M	Coun ary	Land	
D.	*		Usual Residence of 10a. State	Decedent 10b. County	-		10	Oc. City, To	wm or Loc	ation					-		1	Od. Inside City Limi	ite
Aarvis	o h	ō		Carr	a11		"	-	stmin								Ι.	1 ☐ Yes 27€	
a d	28e-	rect	MD 10e. Street and Nur		01.1.			WE	SCINITI	10f. Zi					10a. Ci	tizen of Wh	at Coun	trv?	_
ž.	3e or	Ö	414 Bald	lwin Pa	rks I	rive	т-3					21	157			US.			
should be filed within 72 hours after death with the Maryland	f Health and Menial Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f ehow other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Marri 3 Widowed	ied 2 <mark>∏</mark> Marı	12.	Was Dece Armed For 1 1 Yes If Yes, Gir Year or D	edent Eve orces?		1	J /as Dece Yes, spe □ Yes		ispanic Ori n, Mexicar Specify:	gin? (Spen, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White,		
	atura Gal E	ed		15. Deceden	t's Educat	ion		1	a. Decede	ent's Usu	al Occupa	ation			16b. K	ind of Busin	ness/Inc	lustry	
, id	Media.	Completed	(Spec	ify only higher	st grade c	College (	1-4or 5+)		(Give k life. D	ind of wo O NOT L	ork done d se retired	during mos	t of worki	ng				ŕ	
1 7	or the	Son	12			C			Tecl	nnic	al as	ssist	ant		SS	SA			
3 3	d oth	Be	17. Father's Name											(First, Middle,	_				
<b>7</b>	Men	ို	James J											M. Mort					_
0	h and 7 is n treun		19a. Informant's Na			-								I Route Numbe	,	-			
7 200	Healt em 2 other		Dorothy E		/spoi	ise		20b. Place	of Dispos	ition (Na	me of	1		Westmin		r, MD ocation - Ci		.157 wn. State	
2 8	ant: ff ury or		1 ☐ Burial 2 [ 4 🛣 Donation	☐ Cremation 5 ☐ Other (S	pecify)			_	tery, crem	atory or	other plac	e)					,		
	Depart Import		21. Signature of	onald	Licensee 5 WE	de, I	)irec	tor				of Facility  MD		d 655 W 01	. Ва	altimo	ore	Street	
ı			23a. Part1. Enter the shock, or hea	he disease, or rt failure. List	complica only one	tions that c	aused the	e death. Do							rest,			Approximate Interval Between	
	nysician		Immediate Cause ( disease or condition		a.	le	pher	al c	Jaco	Na	, f	1589.	. (				1	Onset and Death	
	Medical xaminer		resulting in death)			Dug 10	or as a co	onsequenc	e of):		9							Varan	
		- G	Sequentially list con	nditions, nmediate	b	Due to	(or as a co	onunqueno	of):	30	1300	151					_	78975	
5	arsit	Examiner	Sequentially list confidence if any, leading to implement cause. Enter Under Cause (Disease or that initiated events	rlying injury	<b>S</b> .	/	2	/	100	ath	1						1	1405	
,	an an rial-tr	Exa	resulting in death) I	Last	C	Due to	of sac	onsequen	of):	/								1	
o de la companya de l	physician and s the burial-transit	Ical			Cd.														
	ling pl	Medi	IF FEMALE:			4													
be death of	within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-tran	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ⊒No	230		ointh 2 [ nant at tim	Fetal dea e of death		Ectopic p Other (s)	regnancy pecify)					23d. Date o Month		ry Day Year	
that	ned by e dete	by Ph	Part II. Other signif	icant condition	ons contri	buting to d	eath but n	ot resulting	in the un	derlying	ause givi	en in Part I		23e. Did to	bacco	use contrib	ute to th	e cause of death?	
	on sig													1 🗆 Y	'es 2	<b>J</b> 3	☐ Prob	ably 4 Unknow	ΝŊ
3 3	2 sho	Completed												24a. Was		24b. We	re auto	osy findings availat	ble
F 4	ete has l page 2 s	ĕ												autop perfor	med? 2 □ No	dea	th? Yes		"
	ctor,	Be	25. Was case refer examiner?	red to medica	_							26. Place	of Death	Check only o					
hyei	this o	ုင္	1 ☐ Yes 2 ☐		Hos		Inpatient		Dutpatient			4 🗀 🕅		me 5 Resid				)	
	After	i o	27. Manner of Deat	5 Pendir		28a. Date (Mon	of Injury th, Day Ye	ear) 28b	. Time of Injury		28c. Injun World			28d. Describe h	ow inju	ry occurred			
or Attend	within 24 hours after death.  To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Certification;	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	28e. Place buildi	of Injury ing, etc. (S	- At home, Specify)	farm, stre	M et, factor		Yes 2 🗌		28f. Location (S City or Tow	Street an m, State	nd Number e)	or Rura	Route Number,	_
Hospital	24 hours : Funerel	edical Ce	29a. Certifier (Check only one)	Medical	g Physic Examine	r: On the b	a best of m asis of ex	amination a	ge death and/or invi	occumad estigation	at the tin	ne data an pinion, dea	d place: th occurr	and due to the o	auso(s date an	and mann d place, and	er ac et d due to	the cause(s)	
ed c	o the	Mec	29b. Signature and	title ef certifie	10	and mall	mer stated			29	c. License	number			29d. Da	te signed (i	Montb. I	Day, Year)	
Ĕ	3 ⊢ ŏ		•	6/10	5/	1/2	1/		110		Do	200	2-			10/.	/.		
			30. Name and addr	ess of person	who com	pleted caus	se of deat	h (Item 23a	(Type, P	Print)	., ,,,,,	) 01	, /		- (	111	16		
			Wills	1. 10	Las.	29	5 0	ton	/ 1	Are	51	30	7 6	vest.m.	He	MO	21	157	
	Sta Registr		31. Date filed (Mon	th, Day, Year)	2006	32 F	Registrar's	Signature	R	a. 64 s									

		1	For Stata Registrar	State of M	arylan		artment rtificate			and M		giene Reg. No.2	11116	5 3	2768
PI	hysicia		Decedent's Name (First, Middle, Last,     Ansis Erdmanis								2. Date of Dea Month October	Day	2006		me of Death
	/Medic xamin		4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or	Location o		000001		ounty of Dea		
			Frederick Memoria	1 Hospita	11				erick			Fı	rederi		
	neral ector		216-30-346/	M 2□F	78	last birthday) Yrs.	If Under 1 Months	Year Days	If Under:	Min.	8. Date of Birt (Month, Da 11/1	9/192	9. Bi	rthplace (S Country) atvia	State or Foreign
land	A M		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Ins	ide City Limits
Mary	T I	tor	MD Frederi	ck		Fre	derick	ζ.						12	Yes 2 No
ith the	01 28 01 28	Directo	10e. Street and Number				10f. Zip (		700			10g. Citize	n of What C	-	
aath w	a Zon		7421 Willow Rd. U	nit 35 12. Was Decedent	Ever in II	S 13 1	Was Decede		702	ain? (Sne	city Yes or No	. 14	U.S.A		ian.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.	xaminer.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces  1  Yes 2 If Yes, Give Year or Dates:	?		If Yes, specif		Specify:	n, Puerto	cify Yes or No Rican, etc.)		Black, Wh		
5-0C	CalE	ted	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual kind of work	Occupa	ition	t of worki	na	16b. Kind	of Busines	s/Industry	
Athin 1	- Wat	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)	}			Manus	Footus	eina	
Hygie	or to	Co	17. Father's Name (First, Middle, Last)	1		Quali	ty Con	itro.			(First, Middle,		Eactur Jmame)	Ting	
ld be	rked o	To Be	Ansis Erdmanis						Tek1	a Iv	ans				
Maryland 21215-0036 td 2 should be filed within 72 hours af	zy le ma r treuma		19a. Informant's Name/Relationship (7) Shirley Erdmanis				ng Address ( Willo				1 Route Number 5 Fred	-	own, State,		
Baltimore, permit. Pages 1 ar Department of Hee	oth o		20a. Method of Disposition  1 Burial 2 Cremation 3 F	amoval from State	.   0	Place of Dispo semetery, crea	natory or oth	ner place			ate	20c. Loca	ition - City o	or Town, St	ate
Pag ment	ury o		4 □Donation 5 □Other (Specify)		Re	st Hav	en Cem	ete:	ry  1	0/18	/2006		cstowr		la alia
Baltii permit. 1 Departm	eny In		21. Signature of Foneral Service License	Kalm	Ale		Name and unerally controls and unerally cont	Address HOI LODS	s of Facilit me of SVIII	e, M	rningī D 2122	sntoi e, li	ic. I	38-E	itzke Imondson
Me be executed with the beautiful to the executed with the execute	gned by the attending physician and in color in color in color use as the burial-transit in color in c	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any bedring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	11	S a consequence of a co	uence of):	9								al Between t and Death
I Records, P.O. Box 68 The law requires that the death certifica	f the attending I ched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic pre ⊒ Other (spe					23	d. Date of d Month	elivery Day	Year
ds, P.	signed by		Part II. Other significant conditions co	ntributing to death	but not res	ulting in the u	inderlying ca	use give	n in Part I						se of death?
Vital Records, sicien: The law requires t	cete has been si page 2 should	Completed				··-··					24a. Was autor perfo		24b. Were a prior to death?	completic	dings available on of cause of
ita :	is certificete director, pag	BeC	25. Was case referred to medical examiner?	_		70.41			26. Place	of Death	Check only				
on of	After this funeral dii	မှ	1 Tyes 2 No  27. Mannar of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D		28b. Time of Injury		c. Injury Work	4 🗆 190		me 5 Residence 1			pecify)	
Division of To the Hospital or Attending Phy within 24 hours effer death.	To the Funeral Director: completely filled in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	200. Place of It	njury - At h etc. (Specia	ome, farm, st	reet, factory,	office			28f. Location (: City or To		Number or I	Rural Route	e Number,
DIN To the Hospital or within 24 hours efte	letety fille	edical C	29a. Certifier 1 Certifying hy one) 2 Medical Exam	reician: To the bes iner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred a vestigation,	it the tim in my op	ia, data an pinion, dea	id place, ith occurr	and due to the ed at the time,	cause(s) a date and p	nd manner lace, and d	as stated ue to the ca	ause(s)
To th within	To the	Me	29b. Signature and title of certifier				29c.	License	number	/,-	,	29d. Date	signed (Moi	nth, Day, Y	(ear)
,			1/115	MD			D	00	600	11/		10/1	5/ 20	000	
7	5		30. Name and address of person who co Hem en Shah	65-C	death (Iter	1 23a) (Type	Print)	son	D	r.	Frede	ric	K N	10 7	21702
F	Sta Registi		31. Date filed (Month, Day Year) 7 2	006 32. Regis	trar's Sign	ature	JOANS.	),							

		1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a Death	ind Me		giene	006	32	769
Physic		1. Decedent's Name (First, Middle, La	RON	-						Date of Dea Month	Day	Year 2006	3. Time	
/Med Exami		4a. Facility Name (If not institution, give	re street and number)			4b. City, 7	Town, or L	ocation of		-,-,50		ounty of Dea		
		UNIVERSITY OF M							IMOT			IA		
Funeral Director		,	Sex 7. Ag 1 □ M 2 1 F	76	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 0	Date of Birt (Month, Da)	y, Year)	C	thplace (State ountry) N	or Foreign C
land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside (	City Limits
e-f eh	ctor	MD NA		Ba	ltimo	re							1 ( <b>X</b> Ye	s 2 No
or 28	Olre	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Co	ountry?	
ath w 23a	E	4012 Glen Ave						1215				.S.A.		
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Dependment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28e-f ehow any njury or other traumatic event, tra Medical Examinar must be notified at appear.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  **□ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates:			Was Decedi f Yes, speci l ☐ Yes 2			gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	1	Black, Whit	erican Indian, te, etc. 31ack	
5-00	ted	15. Decedent's E (Specify only highest gro			16a. Deced	dent's Usual	Occupat	ion	of working		16b. Kind	of Business	/Industry	
21 21 21 21	Completed	_Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT us	e retired)						Núrs	es
Hygier th	Co	12th grade  17. Father's Name (First, Middle, Last	na ,		Nur	sing				First, Middle,	Exch			
Maryland 21215-0036 at 2 should be filed within 72 hours att lith and Mental Hygiene. 27 is marked other than "natural; or reaumatic event, tra Medical Exemi	To Be	Samuel Best	,							L. Li		mame)		
and he sums		19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailin	g Address	(Street an	d Number	r or Rural R	oute Numbe	r, City or T	own, State,	Zip Code)	
e, No. 1 end lealth m 27		Daphine Ebron-	Daughter	-				e, Ba		more,		2121		
DOF 1998 1 11 of 1 1 if ite		20a. Method of Disposition 1 Burial 2 Cremation 3		Ce	ace of Dispo metery, cren	natory`or oti	her place)	1	Date				Town, State	
Baltimore, permit. Pages 1 el Department of Hea Important: if Item any Injury or othe page.		4 ☐Donation 5 ☐ Other (Special Sign Hurs of Funeral Service Lice	- 75	Gar						18/06	Owi	ngs M	ills,	Md
		> Xmall (	Dhum	K	Ma 43	Name and rch	F/H abas	Wes	t ve, 1	Balti	more	, Md	2121	5
Physician		23a. Pa (1. Enter the disease, or comes ock, or heart failure. List only Immeriate Cause (Final disease or condition	a. Anterio	ne.	. Do not ent	er the mode	of dying,	such as c	cardiac or re	espiratory ar	rest,		Approxima Interval Be Onset and	ite etween
/Medical Examiner	1	resulting in death)	Due to (or as	a consequ	ence of):	010110		171 0		1014		101	6 da	
. 7 =	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ance of).								V CCCC	79
58760, C. icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):								-	
8760, cate be exemply sician a	cal E	(	_ d											
x 68 sentifica ding pt	/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	nov.						- 24			
, P.O. BOX (that the death certified by the attending detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe				·	23d	d. Date of de Month	livery Day	Year
I Records, P.O. Box 61 The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as i	2	Part II. Other significant conditions of Hypertension			lting in the ur	, •							o the cause of	,
ecord law requir las been si	Completed	Hyperlipidem								24a. Was a		4b. Were at	utopsy findings completion of	available cause of
The : The cate t	S									perfor 1 ☐ Yes		death? 1 ☐ Yes		
Vita lician centifi	Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only or				
Vision of Vital Attending Physician: r death. ector: After this certificity the funeral director.	To :	1 Yes 2 No 27. Manner of Death	1 > Inpatie		R/Outpatien 28b. Time of		Ic. Injury a	4   INUI:	7	5 Resid			cify)	
ion nding ath. r: Afte	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	y Year)	Injury	М		s 2 N			,-,-			
Division of Vital Records, if or Attending Physician: The law requires tatler death.  Director: After this certificate has been signed in by the funeral director, page 2 should be to	Certification;	3 Suicide 6 Could not be determined				eet, factory,	office		28f	. Location (S City or Tow		lumber or Ri	ural Route Nui	nber,
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate in completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Pt	nysicien: To the best of miner: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred a restigation,	t the time	, date and nion, death	place, and	due to the cat the time, c	cause(s) an date and pla	d manner as	s stated. to the cause	(s)
To the Mithin To the	Me	29b. Signature and title of certifier				29c.	License r	number		- 2	29d. Date s	igned (Mont	th, Day, Year)	
		1/1/	MD			P	17=	369			30 771	3572 /	7 7 or	6
V		30. Name d address of person who		eath (Item	23a) (Type, I	Print)	BA	LTI	NORE	MD	2120	, 1	2, 200	
		22 SOUTH GRE	ENE ST			1	KRAH	YER	m.I				_	
St Regist	ate rar	31. Date filed (Month, Day, Year)	006 32. Angistra	ars Signak		BAR )								

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 14:42 M /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE PITAL 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Min. Days Months Hours 1 □ M 2 X F 212-20-5543 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Nedical Examinar must be notified at 1 ZYes 2 □ No Funeral Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene. Instruction to the transmission of the marked other than "natural", or item any injury or other traumatic event, the Mandale Feedome. 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Ejementary/Secondary (0-12) 2 HIGRADE 18. Mother's Name (First, Middle, Maiden Sumame) (MN - UNKNCいい) 17. Father's Name (First, Middle, Last) Be KAVMOND 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa t's Name/Relationship (Type, Print) AROL FENWIC Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 Removal from State RISON FOREST 10-4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Z MONTHS Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** 1009 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, hand, leading to ining additional cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner burial-transit and resulting in death) Last Due to (or as a consequence of): been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy performed? res 2 No 2₽No 1 ☐ Yes within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 1 No 2 FR/Outpatient 1 Inpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 5 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier MD October 12, 2006 D47353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Baltomore, Maryland 21229 St. Agres Huspital JON FAICK MID 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State 2006 1 Registrar

#### Please Type or Print in Black Indelible Ink

amela Flayhart		Stat - For State legistrar	e of Marylan		rtment of tificate of		and	Menta	al Hyg		eg. No.	20	06	3277
Physician ledical Examine	1	1. Decedent's Name (First, Middle, L Pamela Flay							2	Date of Dea Month October 1	Day	Year	3	Time of Death 2332 hrs
		4a. Facility Name (if not institution, q Union Memorial Hospita		er)	4	b. City, Tov Baltimo		ocation of	Death		4c. C	ounty of D	Death I/A	
Funeral Director	- 1	214 46 0724	Sex 7.	Age (In yrs. la		If Under Months	1 Year Days	If Under Hours	1.0	8. Date of Bir Feb. 6	,	TF.	oreign	lace (State or ry) Maryland
w any	r	Usual Residence of Decedent 10a State 10b. County		10c. City,	Town or Location								1	Od. Inside City Limits  X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once	ᄋᇈᆫ	10e. Street and Number	N/A 			Baltir 10f. Zip C	ode			1	0g. Citize		Country	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Montal Hygene n 27 is marked other than "natural", or items 23a or 28a-f she unatte event, the Medical Examiner must be notified at one	- L	4300 Falls Roo	12. Was Deced	es?		Decedent es, specify (	of Hisp			cify Yes or No	)- 12			n Indian, Błack,
hours after des 'natural'', or i	≥ -		1 Yes  Ded If Yes, Give Year  or Dates:	No No completed)	16a, Decedent	Yes 2	cupatio	n (Give ki	nd of wo	rk done		pecify:		white
036 ithin 72 houng the true than "main dedical Examination of the true than the true t	Completed	Elementary/Secondary (0-12) 12th	College (1-4	or 5+)	during mo	st of working Line			se retire	d)	Mo	lecra	ıft	
1215-0036 d be filed within 7 lental Hygiene arked other than event, the Medica	å [	17. Father's Name (First, Middle, La  Albert Brown			Laob Mallia	Address		H	elen	Pres	ton		01-1- 7	· Code
MD 21 nd 2 should lith and Mer m 27 is man aumatic ev	- 1	19a. Informant's Name/Relationship Edward Flayhart	Husba	and	4300 I					ral Route Nur 1timor				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other transmants event, the Medical		20a. Method of Disposition  1 Burial 2XX Cremation  4 Donation 5 Other Spec		State	Place of Disposi crematory or oth etro Cre	er place)				Date 4/2006		cation - Ci Onsvi		wn, State , Maryland
Balti permit. Departm Imports injury o	- 44	21. Signe e of Funeral Service Line 23. In I. Enter III, disease, or co	ensee		I Bu	ame and A rgee-1 31 Fa	Tone	ss-Se	itz _ Ba	Funera ltimor	l Hon	me, I arvla	inc.	21211
Physician /Medical Examiner	1	7 It I. Enter III. disease, or confailure. List one cause on Immediate Cause (Final disease or condition resulting in death)	a. <u>Chronic</u>	obstruct	tive pulm				rdiac or r	espiratory arr	rest, shock	k, or Fleart		Approximate Interval Between Onset and Death
e de	<u>آ</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a co											<del></del>
ted d msit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence o	f):								$\dashv$	
50,  te be executed  nysician and burial - transit	Medical	X UNPENDED  IF FEMALE:	AMENDED	3a,PII,2	27. perME,	g861,11	/21/	(06 TT			23d.	Date of de	elivery	
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknown	1 Live birth 4 Pregnan	n t at time of de	2 Fe	tal death ner <i>(Specif</i>	3 [	Ectopic	pregnan	СУ		lonth	Day	y Year
D. E		Part II. Other significant condition	-		_	nderlying c	ause giv	ven in Pari	t I.					e cause of death?
cords, law require has been si	Completed by	Osteoporosis, h	/per tensive	neart (	LSease					24a Was	an psy ormed?	24b. We prid dea	re autop or to con ath?	osy findings available inpletion of cause of
Vital Rec ysician: The this certificate director, page	် ရှိ	25. Was case referred to medical				26		of Death (0	Check or	1 Yes	2 No	1 💆	Yes	2 No
f Vital I Physician: er this certifi	8 2	examiner?  1 ✓ Yes 2 No			ER/Outpatient					Home 5	Residence	-	Other:	
on o lending eath or: Afte the funer	ii l	27. Manner of Death  1 X Natural 5 Pendin 2 Accident Investig		ay,Year)	28b. Time of I			≀at Work? es 2 ☐ I		8d. Describe	now injury	/ occurred		
Division of pipital or Attending Phonts after death ours after death filled in by the funeral	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place o	of Injury - At h	ome, farm, stree	et, factory, o	office bu	ilding, etc	2	8f. Location ( or Town,		d Number	or Rura	Route Number, City
2 C 2 ×	Medical (	one) 2 Medical Exami	sician: To the best of iner: On the basis of and manner stat	examination a	ge, death occur and/or investigat	ion, in my c	pinion,	death occ	ce, and durred at	ue to the cau the time, date	and place	e, and due	to the	cause(s)
The Ve	Σ	29b. Signature and title of certifier	enica-	Polla	k		License O.C.N	number 1.E.			1 -	ber 11,		n, Day, Year)
In box		30. Name and address of person w Patricia Aronica-Pollak		of death (Item t Medical		111 Per	nn Str	eet, Bal	timore	, <b>M</b> D 2120	)1			
Sta Registr		31. Date filed (Month, Day, Year)	100	strar's Signatu	ure Apple	A								

DHMH 17 Rev 1/2001 OCME 2006

				State of Ma	ryland / Depa			•	_	
			1 - For State Registrar			rtificate of			3. No 2006	32772
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
1	/Medio	cal	Reba Frank  4a. Fecility Name (If not institution, giv			4b. City, Town,	or Location of Death	Oct	13 200 ( 4c. County of Dea	
	Examili	iei	Howard Count		Hospita	1	COLUMBI			HOWARD
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 04/16/	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		219-76-7856 Usuel Residence of Decedent	Т Х	90 Yrs.			04/16/	1916	PA
	uryland show	-	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	he Ma	ecto	MD HOWAR	D	COL	UMBIA		10	g. Citizen of What C	1 Yes 2 No
	72 hours after deeth with the Maryland naturel', or iteme 23a or 28a-1 show disal Enacides must be codified at	Funeral Director	5400 VANTAGE PO	INT ROAD	#403	Toi. Zip Code	21044	10	g. Citizen of What C	USA
	deeth	nera	11. Marital Status	12 Was Decedent F	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 A N  If Yes, Give  Year or Dates:	0	1 □ Yes 2 🂢 No			Specify:	WHITE
21215-0036	2 hour	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation	11	6b. Kind of Business	/Industry
215	within 7 iene. then "n	npie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	/ife.	DO NOT use retire	ed) most of wor	rking	OUN HOME	
	filed w Hygier sther th		17. Father's Name (First, Middle, Last		I HUM	IEMAKER	18. Mother's Nan	ne (First, Middle, M.	OWN HOME	
lan	Mental I Mered o artc eve	To Be	MORRIS		PEC	KMAN	ANNA	, , , , , , , , , , , , , , , , , , , ,	,	NEREMBERG
Maryland	shic and iem		19a. Informant's Name/Relationship (	**					City or Town, State,	
	1 and Health em 27 ther tr	12	BARBARA FRANKEL  20a. Method of Disposition	/ DAUGHTE					ORE, MD 21	
Baltimore,	eges ant of I it: If It		1 Ø Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of Dispo cometery, crea				BALTIMOR	
altir	permit. Peg Department Important: I any Injury o		21. Signature of Funeral Service Cice	_//_/	-	2. Name and Addr			SON & BROS	
Ď	Depa Impo any l		Whichou 1	ruger			STERSTOWN	I ROAD - F	IKESVILLE	, MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final						st,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Acy Due to (or as a	te Myoc i consequence of): mi'al Fi	cardial	Infarct	704		hours
Į.	Examiner		Sequentially list conditions	b. 4+	nial Fi	brillat	in			years
	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
Ć,	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
3760,	The law requires thet the death centificate be executed sie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	cal		d						
x 68	entifica ding ph	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy					
Box	death c	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	Day Year
P.O.	thet the de ned by the e detached f	hysi	9 Unknown	9□ Unknown						
	signed be de	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	inderlying cause g	iven in Part I.			o the cause of death?
Records,	w require been si should i	Completed						24a. Was an		
Rec	sician: The law certificete has t irector, page 2 s	dwo						autopsy perform	ed? death?	utopsy findings available completion of cause of
of Vital		BeC	25. Was case referred to medical				26. Place of Dea	1  Yes 2 tath (Check only one		s 2 No
∑ <	Physician: rthis certificantal director, I	၉	examiner?	_	nt 2 ER/Outpatier	11 3L DOX			ce 6 □Other (Spe	ecify)
$\subseteq$	fe fe	tlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injur (Month, Day	Year) 28b. Time o	W	uryat ork? ∃Yes 2 ⊟No	28d. Describe how	v injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Inju	ry - At home, farm, str			28f. Location (Stre City or Town,	eet and Number or A	ural Route Number,
Ö	Ital or irs afte ral Dir led in			building, etc						
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of niner: On the basis of and manner sta	examination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the cau irred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	Mithin To the comple	Med	29b. Signature and title of certifier	210 11211101 312		29c. Licer	ise number	29	d. Date signed (Mon	th, Day, Year)
	1		1 - Baucha	MY	2	Da	12892		Oct 13.	2006
1	)		30. Name and address of person who Francis Chuid		eath (Item 23a) (Type,	Print)	revert 1	2-6	Calmila	2006 In MA 21849
	Sta	ate	31. Date filed (Month, Day, Year)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	r's Signature	W =	- ATMI 1	ir may	- IUMA	A 1-(1) 21099
	Regist		nct 1 7 201	h Maria	. The Assess	ALC.				

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health a  1 - State Registrer  Certificate of Death		ZUUb	32773
	Dhusisi	0.00	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio	al	John Leo Challagher  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of the control of the contro	October	15 2006 4c. County of Death	1145 AM
	Examir	ier	Upper Chesapeake Med ctr Beldir		Harford	Co
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours And 1 Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, 1)		place (State or Foreign adelphia PA
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	72 hours after deeth with the Maryland "nature!", or trems 23a or 28a-f ehow calcal Exactinational be notified at	Director	MD Hartord Del Hir  10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	1 ☐ Yes 2 No
	th with 23a or	ai Di	1306 Scots Nale DR. UnitD 21015		USA	
5	ter dee Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Anned Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Anned Forces? 1 Yes, specify Cuban, Mexican	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Americ Black, White,	
38	72 hours after naturel', or ite	þ	1 Never Married 2 Married 1 Yes 2 No Il Mes, Give 1 Yes 2 No Specify:		Specify: W	nite.
1) <del>[</del>		Completed	15. Decedent's Education (Specify only highest grade completed)  [Second of work done during mos life. DO NOT use retired)	st of working	6b. Kind of Business/In	dustry
1212	be filed withintal Hygiene.	Com	Elementary/Secondary (0-12) College (1-4or 5+) Division Claims	Marager 1	iberty M	lutual INS. Ce
and	id be fil ental H ked ott	To Be	17. Father's Name (First, Middle, Last)  18. Mother  Tohn Leo Gallagher, Se. Flo	er's Name (First, Middle, Ma	io ffort	nocher.
_∂- <u>Ja</u>	s 1 and 2 should be f Health and Mental from 27 is marked other treumatic ev	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number)	er or Rural Route Number,	City or Town, State, Zip	Code)
0	s 1 and f Health item 27 other tr		Katherine Callagher. 1301e Scotsdale 20d. Method of Disposition (Name of	DR. Unit D	Oc. Location - City or To	MD 2/0/3 own, State
15	m 0		1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify)	10/19/06 F	Forest Hi	11.19
Balt	permit. Pege Department Important: If eny Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facilities 3 New Oct 1 De	y Forest Hi	11,MD 210	A A
			23a. Part. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or respiratory arres	estion Servi	Approximate Interval Between
	Physician		Immediate Cause Final Diffuse Large Ce disease or condition	11 Lymph	oma	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a gor/sequence of):			
9	2 W =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<u> </u>		
	ate be executed hysicien and the burial-transit	Examiner	Cause (ciseese or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
3760	cate be executed physicien and the burial-transit	licai	d			
7 ×	certific nding pl	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	arv
	og Physicien: The law requires that the death certific flat this certificete has been signed by the attending prineral director, page 2 should be detached for use as the contract of the cont	Physician/Medical	in the past 12 months? 1   Yes 2   No 9   Unknown   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death 5   Other (specify)		Month	Day Year
<b>∑</b> a.	res that th igned by be detacl	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	I. 23e. Did toba	acco use contribute to t	he cause of death?
) ords	w requires been sign should be	ted b		1 Tes	s 2 ☐No 3 ☐ Prot	oably 4 □Unknown
Sec O	The law retele has be page 2 sh	Completed		24a. Was an autopsy perform	ed? death?	opsy findings available impletion of cause of
1	iician: The tav certificete has rector, page 2	Be Co	25. Was case referred to medical examiner?	1 ☐ Yes 20 e of Death (Check only one	1 ☐ Yes	2□ No
3	Physic this ce	ှင	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ No	ursing Home 5 Residen		(y)
allagh of Vital	tending Physician: leath. tor: After this certific the funeral director,	ation	27. Manner of Death  1		r injury occurred	
	or Atterities de Directo	rtific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
( p	To the Hospitel or Attendivitin 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification:	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are (Check or V)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date are (Check or V)  20 Medical Examiner: On the basis of examination and/or investigation in my oninion death.	nd place, and due to the cau	use(s) and manner as s	stated.
	the Ho thin 24 the Fu mpletel	Medic	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.  29b. Signature and title of certifier  29c. License number		d. Date signed (Month,	
	To To Cor		M.D. D453	190 0	ctoberi	7,2006
	ist 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mup Min (M.D.) 602 South Atwood Roo	1 # 200 F	Bel Ain A	ID SINK
	Sta	ate	31. Bufte filed (Month, Day, Year) 32. Registrar's Signature	W THE CO		WIZIUIT
	Regist	rar	OCT 1 7 2006 Bares A A			

			For State Registrar	State of Maryland / [	Department of He Certificate of D	ealth and Mental H Peath	ygiene 006 Reg. No.	32774
i	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Wayven (1)	Mon		2. Date of I Month	Death Day Pear POOD POOD	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give st  NOV WCST  5. Social Security Number  217-56-7856	OSPHAL CENTE 7. Age (In yrs. last bir	4b. City Town, or L thday) If Under 1 Year Months Days	If Under 24 Hrs. B. Date of E	4c. County of Death  3c. +1  3irth 2ay, Year) 2, 1951	Place (State or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location			10d. Inside City Limits
	Mary Fe sho	tor	MD Baltimore	Ва	ltimore			1 ☐ Yes 2√ No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
	eath w	erai	3608 Yennar Lane #	2. Was Decedent Ever in U.S.		21244	USA No- 14. Race - Americ	
036	ours after do ral', or Item Examinar	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? unk  1 Yes 2 No If Yes, Give Year or Dates:		panic Origin? (Specity Yes or N Mexican, Puerto Rican, etc.) Specity:	Black, White,	etc.
1215-0036	be filed within 72 hours after death with the Maryland all Hygiene. Ide Hygiene. Ide ther than "natural", or iteme 23a or 28a-f show other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) unk	completed) College (1-4or 5+)	Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)	ion unk ring most of working	16b. Kind of Business/In	ndustry unk
Maryland 21	4 a 2	Be	unk un 17. Father's Name (First, Middle, Last)	K	unk 1	IB. Mother's Name (First, Midd	le, Maiden Sumame)	unk
ary ii	should be and Mental marked o	T <sub>O</sub>	19a. Informant's Name/Relationship (Typ	e, <i>Print</i> ) 19b	. Mailing Address (Street and	nd Number or Rural Route Num	nber, City or Town, State, Zip	code)
	1 and 2 Health a tem 27 la		Northwest Hospital			Court Road Rand		
Baltimore,	Pages lent of nt: If It		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☑ Other (Specify)	in state	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or To	own, State
Ball	permit. Departm Importe sny inju		21. Signature of Funeral Service Licenser RODALO S W	ade lirector	State Anato	ർണ്്ജ് Board 655 MD_ 21201	W. Baltimore	Street
a day	Physician /Medical Examiner		23a. Part Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, b.	e cause on each line.	DHC COVA	such as cardiac or respiratory  1000 CUCA  May DAHA	n	Approximate Interval Between Onset and Death
58760,	ificate be executed g physicien and as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a contraquence	4011SICV			
_	ding pl	/Med	IF FEMALE: 23	c. If yes, outcome of pregnancy			22d Date of delice	
.O. Box	The law requires that the death certif site has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause given		tobacco use contribute to the second of the	
Division of Vital Records,	The law re sete has bee page 2 sho	Completed					formed? death?	opsy findings available impletion of cause of
V Ita	ysician: The is certificate his director, page	Be	25. Was case referred to medical examinar 1	ospital:	Othor	26. Place of Death Check only		
on of	ding Ph .r After th funeral	ation: To	27. Manner of Death  Natural 5 Pending investigation	28a. Date of Injury 28b. 1	Fime of njury 28c. Injury a Work?	4 □ Nursing Home 5 □ Re	sidence 6 □Other (Specified how injury occurred	y)
DIVIS	el or Attendi s efter death il Director: A id in by the f	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location City or T	(Street and Number or Rura own, State)	al Route Number,
	To the Hospital or Attentwithin 24 hours effer death To the Funerel Director: completely filled in by the	ledicai C	29a. Certifier (Check only one)	cian: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death occurred at the time, d/or investigation, in my opin	, date and place, and due to the nion, death occurred at the time	e cause(s) and manner as s e, date and place, and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	i. Westde	29c. License r	number	29d. Date signed (Month,	Day, Year)
1			· wall	WHUILIU	4HU DOO	52760	octoner 5,	, 2006
			Erica Tobin	Muldrow	(Type, Print) HD 5401	old Cour	+ Road Pa	ydallstoren
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 2008	32 Registrar's Signature	garle?		margiane	1 21133

State of Maryland / Department of Health and Mental Hygien 2006 32775 1 - State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALBERT GARDNER OCTOBER 2006 7:37 P. M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1፟∑M 2□F Hours Yrs. Director 008-20-2403 75 Vermont Usual Residence of Decedent death with the Maryland 10a. State 10b. Count itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 ☐ Yes 2√ No MD Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Parkshire Court 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No If Yes, Give Year or Dates: 151-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. 8m 27 is markad other than "natural", or Ital Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 attorney/CPA private practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Perley Joseph Gardner Cornelia Scribner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 to Nancy E. Gardner/spouse 2718 Parkshire Court Fallston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. ` 4 XDonation 5 ☐ Other (Specify) 21. Signature of coneral Service Licensee Ronald S. Wade Director State AAAtomy Bard 655 W. Baltimore Street mn Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 21201 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final Parhungen des Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760 physician IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death Day 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2√Q No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After I 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation s after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai The destinance of the destinance as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 @ 32257 actile 6,200 ( 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN 615 W. MACPHAIL ROAD - BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

			1 - For State Registrar	State of M	laryland / I		tment of H		and Men		iene .g. 2006	32776
			Decedent's Name (First, Middle, Las	t)						Date of Deat	th	3. Time of Death
	Physici /Medic		Joseph John G1	orioso, J	r.					Month CT	Day Ye.	06 10 23 PM
	Examir		4a. Facility Neme (If not institution, give	street and number	)	4	b. City, Town, or	Location o	of Death		4c. County of D	eath
			SAINT AGNE	S HO		_	BALT		ORE			
45	Funeral Director		5. Social Security Number 6. S 217-05-5184	9X 7. A □X M 2 □ F	ge (In yrs. last bi 90		If Under 1 Year Months Days	Hours	Min. (	Date of Birth Month, Day, b. 27	Year)	Birthplace (State or Foreign Country) aryland
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	un or Loon	tion					10d. Inside City Limits
	anyla ehov	ž	· ·									1 ☐ Yes 2 ☒ No
	the N	Director	Maryland Baltimo	re	E	Balti	more 10f. Zip Code			1	0g. Citizen of What	
	with with		2521 Gehb Avenue					1227			USA	oddiniy.
	ms 23	Funerai	11. Marital Status	12. Was Deceden		13. Wa	s Decedent of Hi		gin? (Specify		14. Race - A	merican Indian,
36	d within 72 hours after death with the Maryland jiene. r then "naturel", or teme 23a or 28e-f ehow the Medical Exa offer met the motified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces  1 ☑ Yes 2 ☐  If Yes, Give			'es, specify Cubai ]Yes 2∰No	n, Mexican Specify:	i, Puerto Rica	n, etc.)	Black, W Specify: W	/hite, etc. hite
21215-0036	ture!	ed	15. Decedent's Ed			a. Deceder	nt's Usual Occupa	tion			16b. Kind of Busine	ss/Industry
15	n "na	Completed	(Specify only highest gra	de completed)		(Give kir.	nd of work done d NOT use retired,	urina most	t of working			,
212	d within giene. ir then "	Eo	Elementary/Secondary (0-12)	College (1-4or	3+)	For	eman				Bethlehen	Steel
b	be filed itat Hygid of other event, II	BeC	17. Father's Name (First, Middle, Last)					18. Mothe			Maiden Sumame)	
<u> </u>	should be ind Menta i marked umatic ev	T0	Joseph John Glor	ioso, Sr.					Anna V	/inci		
Maryland	and and series		19a. Informant's Name/Relationship (	Гуре, Print)	191	b. Mailing	Address (Street a	nd Numbe	r or Rural Ro	ute Number	, City or Town, Stat	e, Zip Code)
	1 and 2 Health em 27		Joanne M. Wood	Daughter			al Drive	; Pas	sadena,			
Baltimore,			20a. Method of Disposition 1 28Burial 2 Cremation 3		cemete	ery, cremai	tory`or other place				20c. Location · City	
tim	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify 21. Signature of Filteral Service Uice)		Lake		Mem. Pa				Sykesvill	ab Witzke
Ba	permit. Page Depertment of Important: If eny Injury or once.		21. Signatur 11 eral Service Coe		M0/28	. Fi	uneral H	ome c	of Cato	nsvil	le. Inc.	, MD 21228
*	* **		23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only	olications that cause	d the death. Do	not enter	the mode of dying	, such as	cardiac or res	piratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(1)	RI		-MDN					Onset and Death
	/Medical Examiner		resulting in death)		s a consequence	of):			5			
	Lammer	_	Sequentially list conditions,				INE	CAI	RDIO	MXA	PATHY	XEARS
	ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence	or):						
٦Ď.	xecul and al-trar	Examine	that initiated events resulting in death) Last	c Due to (or as	s a consequence	of):						
8760,	cate be executed physicien and the burial-transit	dicai E		d								
9	g phy as the	edi		, W.								
Вох	death certific e attending p ed for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2  Fetal deatl	h 3∏E∂	ctopic pregnancy				23d. Date of	
	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		ther (specify)				Month	Day Year
P.0	thet the de ed by the deteched		Part II. Other significant conditions c	ontributing to death	but not resulting	in the unde	arlying causa give	n in Part I.		23e. Did tob	pacco use contribut	e to the cause of death?
Division of Vital Records,	8 8 9	d by	LOPD							1 🗆 Y	es 2 □ No 3 <b>)</b> Z	Probably 4 Unknown
CO	>	ompleted								24a. Wasa	n 24b. Were	autopsy findings available
Re	0 - 0	mo.								autops perform 1 Yes 2	med?_ deat	to completion of cause of 1? ∕es 2□ No
ital	icien: Th certificate rector, pag	Se C	25. Was case referred to medical					26. Place	of Death (Ch			63 20110
<b>/</b>	S 5	To B	examiner? 1 Tes 2 No	Hospital: 1 Thepat	ient 2 ER/O	utpatient	3 DOA Othe	r: 4 🗆 Nu	rsing Home	5 🗆 Reside	ence 6 Other (S	Specify)
n o	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. ay Year)	Time of Injury	28c. Injury Work	at ?	28d.	Describe ho	ow injury occurred	
sio	Attending it death. ector: Atter by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					/es 2 🗆 !				
Divi	Dig of	Certification:	4 Homicide determined	28e. Place of Ir	njury - At home, f itc. <i>(Specify)</i>	arm, street	t, factory, office			City or Town		Rural Route Number,
	Hospital 24 hours a Funeral I	edical C	(Check only 2 Medical Exam	ysician: To the bes niner: On the basis	of examination at	ge, death o	ccurred at the tim	e, date an	d place, and o	due to the ca	ause(s) and manne ate and place, and	as stated.
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner s	tated.		29c. License	number		2	9d. Date signed (M	onth, Day, Year)
)	4 ∓ €		1 -nel	m.			P 2		54		OCT,	16 2001
•	EXI		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Pri						0,2006
	dD./		MUDDASSIR	ANA.	900 0	5. C	ATON	AV	ENU	IE, F	BALTIM	10RE, 21229
6	Sta		31. Date filed (Month, Day, Year)		trar's Signature	1	2.8. 9					/
	Registi	ar	96111	-UUU	Willed S.	A SUPERIOR	Contract of the second					

		For State Registrar	State of Marylan	id / Di (	epartment of F Certificate of	lealth and M <i>Death</i>	lental Hygi Re	ene 006	32777
Physic		Decedent's Name (First, Middle, L  CHAC		س.			2. Date of Death Month OLTOBES	Day Year	
/Med Exami Funeral	ner	4a. Facility Name (If not institution, gradulty) 5. Social Security Number 6.		(TA	Z F	r Location of Death  ADAU  If Under 24 Hrs.  Hours Min.		4c. County of Dea	
Director		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town	or Location		Jan. 50	, 1922 Ma	10d. Inside City Limits
ith the Ma	Director	Md. Baltimo:	demus Rd. P.O.		terstown  10f. Zip Code	136	10	Og. Citizen of What C	
ife, Marylating ZIZIO-0000 stand 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, it a Medical Examinar must be recitified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?		13. Was Decedent of Hif Yes, specify Cubi		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,
IIG Z IZ IS-UC be filed within 72 hou al Hygiene. I other than "natura went, the Medical E	Completed	15. Decedent's (Specify only highest g	Education	(	Decedent's Usual Occup Give kind of work done life. DO NOT use retired Wild Life N	during most of work d)	ing 1	16b. Kind of Business Dept. of	Mndustry  Natural Res.
aryland a should be filed and Mental Hygi a marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Las Charles L. (		1		18. Mother's Name	e (First, Middle, M Shipley		
C, Mary 1 and 2 shou Heelth and M Iem 27 ie mer	-	19a. Informant's Name/Relationship Brenda Schne	<i>(Type, Print)</i> ider — Daughter	1	Mailing Address (Street O. Box 74,		town, Md.	21136	
Dalltimore, permit. Pages 1 an Department of Heel Important: If Item ony injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	Removal from State	emetery	Disposition (Name of crematory or other place rk Cemeter;	y Oct.	18,2006 I	Reistersto	
Danit. Dermit. Depart Import		21. Signatury 1 Funeral Service Lice  23a. Part1. Enter the disease, or co	1/		22. Name and Addre Eckhardt 1 11605 Reis	ss of Facility Funeral Cl sterstown	hapel, P. Rd., Owi	.A. ings Mills	. Md. 2111 <i>7</i>
Physician /Medical		23a. Paff1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	sci	EROTIC				Opent and Death
portous icate be executed xx physicien and xx s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o						
OX OO/OU n certificate be e anding physicier use as the buri	//Medical	IF FEMALE: 23b. Was decedent pregnant	d	ancy				23d. Date of de	livery
deatl	Physician/M	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown		3 □Ectopic pregnancy 5 □ Other (specify) _	'		Month	Day Year
law requires thet the as been signed by the 2 should be detached.	<u>چ</u>	Part If. Other significant conditions	contributing to death but not res	ulting in t	the underlying cause giv	en in Part I.		acco use contribute to	o the cause of death? robably 4 (∑Unknown
The The page	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of s 20 No
DIVISION OF VICATION To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate the completely filled in by the funeral director, page	ertification: To Be	25. Was case referred to medical examiner?  1   Yey 2   10  27. Manny rof Death 1   Natural 5   Pending investigati 3   Suigide 6   Could not	28a. Date of Injury (Month, Day Year)	ER/Outp 28b. Tir Inj	me of 28c. Injur	er: 4 🗆 Nursing Ho	h <i>Check only o</i> ne ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spe	cify)
DIVI bital or Att urs after d rel Direct	O	4 Homicide determine	d 28e. Place of Injury - At his building, etc. (Specif	y) 			City or Town,		
the Hosp thin 24 hor the Fund mpletely fi	Medical	29a. Certifier (Check only one)  2 Medical Extended Service and title of certifier	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, ition and	death occurred at the tir or investigation, in my o	ppinion, death occurr	red at the time, da	use(s) and manner at te and place, and dur dd. Date signed (Moni	e to the cause(s)
N W T O		* Mahul	2 Kotu	MI	1	43421	2.5		14,2006
10		30. Name and address of person wh .MUNTEL ROTTOW 31. Date filed (Manth. Day, Year)	5 40 0 0 0 32 Fedistrar's Signa	DC	ype, Print) OURT ROAD	RANDA	USTON	изгус	pr 21133
Si Regis	tate trar	31. Date filed (Manth Day, Year)	006	k	Snack ,			/	

ORIGINAL

			Chate of Maniford / Department of Health and Mantal Husing	
			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. N2 0 0 6 3 6	2778
	95 D &		Registrar Certificate of Death Reg. N&C 0 0 0 0	ime of Death
~	Physici	an	Month Day Year	-12 Рм
	/Medic Examin		4a. Facility Name (If not institution, give street and plumber)  4b. City Town or Location of Death  4c. County of Death	
	LAGITIT	:ei -∋	Good Samaritan Hospital Baltimore NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Social Security Number 1 of Security Number 1 of Security Number 24 Hrs. 8. Date of Birth 9. Birthplace (Social Security Number 1 of Security Number 1 of Security Number 24 Hrs. 8. Date of Birth Occupity) 9. Birthplace (Social Security Number 1 of Security Number 2 of Security N	State or Foreign
<i>E</i> :	Director		Usual Residence of Decedent	pland
	land ow		The state of the s	side City Limits
	Mary	to	Md. N/A Batimore	yes 2 No
	h the	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	within 72 hours after death with the Maryland ene. than 'natural', or Iteme 23e or 28e-f ehow the Maxical Execution chast be inclified at			
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi	ian,
36	irs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes or Dates: Specify: Specify: Specify:	ell
21215-0036	72 hours	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working	
21	1 within 72 ho jiene. r than "natur ine Madical	nple	Elementary/Secondary (0-12) College (1-4or 5+)	100
	T3 C2 No. 100			~
Maryland	d a b v	Be c		
<u>Z</u>	d 2 should th and Men 7 Is marke traumatic	To	19a. Informant's Name/Relationship (Type, Print); 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Suc Code)	
	12 7 15 17		Renee Gordon - daughter 1533 Tunlaw Rd. Bacto, md. 2121	0
ore,	S == 0		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	ate
Ĕ	Pag nent ant: I		4 Donation & Other (Specify) Arbutus mem. PX 10/20/06 Arbutus, n	nd.
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Juneral Service Licenses 22. Name and Address of Facility 270 Fred + 1 Lion Pass	
Ž.	40360	H	23a. Pary Entertheursease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Appro	2/279 eximate
			shock for yeart failure. List only one cause on each line.	al Between t and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Septic Shock  Due to (or as a consequence of):	
Α.	Examiner		Line sonsis	
	D =	ner	Sequentially list conditions, if any, leading to minimize and sequence of joint cause. Enter Underlying Cause (Disease or injury	
4	and trans	Examiner	Cause (Disease or injury that initiated events c.  Pue to (or as a consequence of):	
12097	e be executed /sicien and e burial-transit	cal E		
687	W 2 0	olbe	d	
Вох	eath certi attending I for use a	n/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery	
	death	Physician/Medi	in the past 12 months?  I Dive birth 2 Fetal death 3 Ectopic pregnancy  I Pregnant at time of death 5 Other (specify)  Month Day	Year
P.0	that the de led by the a detached	Phy	9 Unknown	
Ś	8 50	by	Part ii. Other significant continuous contributing to death but not resulting in the underlying cause given in Part i.	,
Ö	w require been si should I	etec	Enal Stage renal au sease on	
of Vital Record	The law ate has page 2:	Completed	hemodialysis  24a. Was an autopsy find prior to completion death?	n of cause of
<u>a</u>		e Co		<u> </u>
Ž	S S	To B	examiner?	
0	ding Ph th. After th funeral			
Sio	tendii eath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	
Division	or At after d Direct in by	Certification:	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)	Number,
	Hospital or Attend 24 hours after death 25 Funeral Director: / 61ely filled in by the f			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call and manner stated.	iuse(s)
	To the within To the comp	ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Ye	ear)
	<b>;</b> .		Junkheyee MBChB RES 000 October 13 20	106
	3		296. Signature and title of certifier  J Mukheyee MBChB  RES 000  October 13 20  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  T. Mukheyee 5601 Loch Rowen Boulevard Baltimore mD  21239	
	Sta	ete-		
	Registr			

Shirley Gordon

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		iai yiai i		Certificate of		, ,	leg. N2 0 0	6	327	79
2	Physici /Medic		1. Decedent's Name (First, Middle,	Margaret V	irgin	ia G	Goodman		2. Date of Dea Month Octob	er 12 20	66	3. Time of 5:30	Death A M
	Examin		4a. Facility Name (If not institution, Greater Baltimo			er	4b. City, Town, o	r Location of Death		4c. County of Baltin			
	Funeral Director		161-20-2897	. Sex 7. Ad 1 ☐ M <b>XX</b> F	ge (In yrs. la 83		day) If Under 1 Year Months Days	If Under 24 Hrs.   8 Hours   Min.	3. Date of Birth (Month, Day 1–29–19	7, Year) 223 M	Coun	lace (State o ltry) Land	r Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town	or Location				1	0d. Inside Ci	ty Limits
	e Man ta-f sh	ctor	Maryland N	I/A			Baltimo	re				<b>™</b> Yes	2 □ No
+	death with the Maryland rms 23a or 28a-f show r must be notified at	ral Dire	10e. Street and Number 3838 Roland Aver	nue Apt. 1	003		10f. Zip Code	21211	1	10g. Citizen of Wh	at Coun	utry? USA	
argar E	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:	? No		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	ify Yes or No- ican, etc.)	Specify:	White, w	etc. hite	
5.7	in 72 h "natu ledica	olete	15. Decedent's (Specify only highest	grade completed)		16a. [	Decedent's Usual Occup Give kind of work done i life. DO NOT use retired	ation during most of working d)	,	16b. Kind of Busin	ness/Inc	dustry	
212	d with glene.	)omb	Elementary/Secondary (0-12) 7th	College (1-4or	5+)		ssembly line			Black	& D	ecker	
an, $Margaw$ Maryland 21215-0036	uld be file Mental Hy irked othe	ro Be C	17. Father's Name ( <i>First, Middle, Le</i> Charles Albert V	•				18. Mother's Name ( Grace M		,			
mαn, ore, Maryl	12 sho n and l is ma rauma		19a. Informant's Name/Relationship			[	Mailing Address (Street						
re, F	Health		James Goodman, 2  20a. Method of Disposition	Jr. So	20b. Pl	ace of I	Sisposition (Name of	Da		sup, MD 2			
ood m Baltimore,	tt. Pages rtment of rtant: If II		₩₩ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control Con	ecify)			rem-Steltze	s Cem. 10/				ship,	PA
	Depar Impor any Ir		21. Signature of Funeral Service th	Charles la			22. Name and Addre Burgee—Hens 3631 Falls	ss of Facility ss-Seitz F Road Bal	uneral	Home, Ir	ıç.	21211	
D			23a. Part1. Enter the dise , or co shock, or heart failure. List or	omplications that cause	d the death line.	. Do no	ot enter the mode of dyir	ng, such as cardiac or	respiratory arr	rest,	I.G.	Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)		515							Onset and I	Jeath
	/Medical Examiner			Due to (or as	s a consequ	ence of	):						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underlying that initiated events	b Due to (or as	s a consequ	ence of	):						
	rificate be executed by physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a consequ	ence of	):				-		
68760,	te be e ysician e buris			d									
89	ertifica ing ph e as th	Medical	IF FEMALE:		-								
P.O. Box	Attending Physician: The law requires that the death certificate be executed rideath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal	death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/	100	23d. Date of Month		•	Year
o.	s that i ned by e detar	y Ph	Part II. Other significant condition	*	but not resu	lting in t	the underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to th	ne cause of d	eath?
ords	equire een sig ould b	ted b	colon c	ancer					1 🗆 Y	es 2 <b>⊡</b> 1√0 3	☐ Prob	ably 4 □l	Jnknown
Division or Vital Records,	The law rate has be page 2 sh	Comple							24a. Was a autops perfor 1  Yes	sy prid med? dea	ath?	psy findings mpletion of ca 2 1 No	available ause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			oationt 3 DOA Oth	26. Place of Death					
0	g Physer this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manper of Death	28a. Date of Inj	jury	28b. Ti	me of 28c. Injur	4 LI Nursing Hom		ence 6 Other ow injury occurred		y)	
Sion	ending sath. or: Aft the fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no		ay rear)	Inj		Yes 2 □ No					
Divis	tal or Att s after de al Direct ed in by l	Certific	4 ☐ Homicide determin	ed 286. Place of in building, e	etc. (Specify	)	n, street, factory, office		City or Tow				ber,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical Certification: To	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the besi xaminer: On the basis and manner s	of examinat	vledge, ion and	death occurred at the tile for investigation, in my control	me, date and place, ar opinion, death occurre	nd due to the d d at the time, d	cause(s) and manr date and place, an	ner as st id due to	tated. the cause(s	;)
	Within Within	Σ	29b. Signature and title of certifier	Conjuli	11.	Λ	29c. Licens	F12117		29d. Date signed (		,	
			30. Name and address of person w	ho completed cause of	death (Item	23a) (T	you Print)	51347		10/12/	06		
	<u>'</u>			iano M.	0 6	70	N. Chari	ies St. Ba	ltin	rore M.	0	21204	<i>L</i>
- 1	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 7 2	32 Regist	trar's Signat	ure	ype, Print)  N. Charl					_	

Registrar DHMH 17 Rev 1/2001

# BENJAMIN GIBBS

	For State Registrar	State of Maryland /	Department of H Certificate of I		Reg. No	4000	32780
	Decedent's Name (First, Middle, L.)	ast)	Commodic or i		Date of Death		3. Time of Death
cian lical	Benjamin	Lawrence	Gibbs	Sr.	Month Da	8 2006	3:20 pM
aı er	4a. Fecility Name (If not institution, gi	ve street and number)	4b. City, Town, or	Location of Death		. County of Deat	7
E.		HINGTON MEDICAL	- 17 C	ENBURA	and the same of th	NNE	
	5. Social Security Number 6. 213–26–6237	Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year	9. Birt	hplace (State or Foreign untry)
-	Usual Residence of Decedent	76	113.		oct30,192	9	MD
ľ	10a. State 10b. County	10c. City, Tov	n or Location				10d. Inside City Limits
rutieral Director	MD Anne Ar	undel Glen	Burnie				1 ☐ Yes 2 No
:	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	untry?
3	604 Minnerva Roa		21061			S.A.	
;	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify in, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify: V	Thite
	15. Decedent's I		. Decedent's Usual Occupa (Give kind of work done of	ation	16b. l	Kind of Business/	Industry
Completed	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	nost of working			
	12	4)	Engine Man	18 Matheda Nama /F		avy	
Be	17. Father's Name (First, Middle, Las			18. Mother's Name (F		n Sumame)	
္	Lawrence Erwin G  19a. Informant's Name/Relationship		b. Mailing Address (Street a	Winona Bos	-	or Town State.	Zin Code)
	Mrs. Mary Ann Gi		604 Minnerva				
	20a. Method of Disposition	20b. Place o	of Disposition (Name of ery, crematory or other place	Date	20c. L	ocation - City or	
	1 Donation 5 Other (Spec	_Hemoval from State	gton Natl.Cei	110/2//2	2006 Ar	lington	. VA.
- 1	21. Fig ature of Juneral Sovide Life	ensee	22. Name and Addres	ss of Facility Singl			
	Remarke Oll	el 11101364	1 Second	Avenue SW C	Glen Burn		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do y one cause on each line.	not enter the mode of dyin-	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a ACUTE	HEPATIT	15 13			Oliset and Death
	resulting in death)	Due to (or as a consequence	of):				
ē	Sequentially list conditions, if any, leading to immediate	b. Due to for as a consequence	_/				
amin	cause. Enter Underlying Cause (Disease or injury	HEPATI	CFAL	LURE			
Exa	that initiated events resulting in death) Last	Due to (or as a consequence					
		d					
Physician/Medicai	IF FEMALE:						
an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat				23d. Date of del	ivery Day Year
\ <u>s</u>	1 Pes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			1410/14/1	bay roa.
		contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ompleted by		ASCULAR			1 ☐ Yes 2	2 □ No 3 <b>X</b> (Pr	obably 4 Unknown
lete					24a. Was an	24b Were au	topsy findings available
E C					autopsy performed?	prior to death?	completion of cause of
9	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2 N	o 1 ☐ Yes	25X No
0	examiner? 1 🗆 Yes 2 🕱 No	Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA			6 ☐Other (Spe	cify)
L ii	27. Manner of Death 1 Natural 5 Pending		Time of 28c. Injury Work		I. Describe how inju		
atic	2 Accident investigati	on		Yes 2 □No			
Certification:	3 Suicide 6 Could not determine		arm, street, factory, office	28f.	Location (Street a City or Town, Star		ıral Route Number,
1 00	29a. Certifier 1 Certifying F	hysician: To the best of my knowledg	e, death occurred at the tin	io, uate and place, and	une to the cause(	and manner as	SIEIOU.
Medical	(Check only 2 Medical Ext	aminer: On the basis of examination a and manner stated.	nd/or investigation, in my of	pinion, death occurred a	at the time, date ar	nd place, and due	to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAM/R

TA/N 301 Hospital Drive Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

2006 32. Registrar's Signature.

DOO61832 OCTOBER 8, 2006

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) OCT 1 7 2006

32. Registrar's Signature

D 19558

who completed cause of death (Item 23a) (Type, Print) 716 Maidenchoice Lane Suite 205 Johnson MD. Baltimore Maryland 21228

10.13.2006

maryland

		For		/ Department of	Health and M		2006	32782
		1 - State Registrar  1. Decedent's Name (First, Middle, Last)	1	Certificate of	Death	Reg. N		3. Time of Death
Physic /Med	lical	4a. Facility Name (If not institution, give stre	J 65-C NV		or Location of Death	October D	Year 2 006	6:45 PM
Exam	iner	St. Elizabett	1 Nursing	Center	Balt	imore	n/a	
Funera Directo			7. Age (In yrs. a. 86	st birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Yea March 9,	r) 1920 Penn	lace (State or Foreign try) Sylvania
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			1	0d. fnside City Limits
e Mary Sa-f sh	ctor	MD Baltimore	Hale	ethorpe				1 ☐ Yes 2 💢 No
with the a or 24	Funeral Director	10e. Street and Number		10f. Zip Code			citizen of What Coun ted State:	•
death	nera	1117 Raven Drive 11. Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	3. Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto I		14. Race - Americ Black, White,	an Indian,
Dallimore, Mary lattic Z.I. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic avant, the Moursal Experiment into a partition at	۾	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 N Yes 2 No Jan ff Yes, Give Year or Dates: Apr	43 1 Yes 2 N	o Specify:		Specify: Whi	te
in 72 h	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	e during most of working	ng 16b.	Kind of Business/Inc	dustry
d with giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Foreman			Riggins	Company
be file of oth	Be	17. Father's Name (First, Middle, Last)  John Gardini			18. Mother's Name Alice De	(First, Middle, Maide	ın Sumame)	1
should nd Mer marke	2	19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Address (Stree			or Town, State, Zip	Code)
and 2 and 2 salth a n 27 ls		Sharon A. Warner / o	daughter	697 East Mai	in St Winte			
Pages 1 avent of Heal		20a. Method of Disposition  1 ⚠ Buriaf 2 ☐ Cremation 3 ☐ Ren	loval from State	ace of Disposition (Name of metery, crematory or other pi raine Park			Location - City or To	
permit. Pages Depertment of Important: If it any injury or o	ė	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	\		ress of Facility Amb		odlawn, Ma ral Home	The
Depermine of the part of the p	Ŕ	May Dally	Seal	1328 Sulp	hur Spring	Rd Arbuti	ıs, Maryla	and 21227
Physiciar	1	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	Do not enter the mode of d	1 1			Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (or as a conseque	ence of):	CI.			Vears
	Jer J	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or infury	Due to (or as a conseque	ence of):	ilil			y CW
ou, be executed icien and burial-transil	Examiner	Cause (Disease or infury that initiated events c. resulting in death) Last	Due to (or as a conseque	iabetes	mellit	US		years
/ou,	cai	L <sub>d</sub> .						
Certificate nding phy use as the		IF FEMALE:						
Geath death death	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 Ectopic pregnan			23d. Date of delive Month	ory Day Year
ecords, F.O. law requires that the as been signed by th 2 should be detache	by Ph	Part ft. Other significant conditions contri	buting to death but not result	fting in the underlying cause of	given in Part f.	23e. Did tobacco	o use contribute to th	ne cause of death?
Ords require een sig	ted t	Rypertension	n			1 Tes	2 No 3 Prob	ably 4 Unknown
The lay	Completed	Typerlipic	demia			24a. Was an autopsy performed?	prior to coi death?	psy findings available mpletion of cause of 2 No
Or VICAL Physicien: 1 this certificat ral director, pi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1 ☐ fnpatient 2 ☐ E	ER/Outpatient 3 DOA	26. Place of Death	n (Check only one) me 5 ☐ Residence	6 Other (Specif	w)
P P P	-			28b. Time of 28c. In		28d. Describe how in		<i>,</i>
DIVISION of or Attending stater death. I Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, factory, offic	J.O	28f. Location (Street City or Town, Sta		I Route Number,
Hospit 4 hour Funera tely fille	Medical		r: On the basis of examination	viedge, death occurred at the ion and/or investigation, in my	time, date and place, a opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as si and place, and due to	tated. the cause(s)
To the Vithin 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		nse number		Date signed (Month,	
\		<b>&gt;</b>	mila	0	55391	0c	tober 12	-,2006
212		30. Name and address of person who com	pleted cause of death (Item	enue Ba	Itimore	, Mary 1	and 2	75512
S Regis	State strar	31. Date filed (Month Pax Year) 2001	32 Registrar's Signatu	ure factor		/		

DHMH 17 Rev 1/2001

		State of Maryland / Departs	ment of Health and Mental H	ygien 2006 32783
		For State Registrar  Certif.  Decedent's Name (First, Middle, Last)	icate of Death	Reg. No.
Physicia		Vanessa Hutchins	Month	Day Year 13 47 M
/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b	City, Town, or Location of Death	4c. County of Death Baltimore
Funeral Director		216-68-7396 1□M 2⊠F 50 Yrs. M	Under 1 Year If Under 24 Hrs. 8. Date of E (Month, I July	Jarrh (Jay, Year) 4 1956 Maryland
land ow		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	nc	10d. Inside City Limits
a-f sh	ctor	Md Baltimore Baltimore		1 AYes 2 No
th with the 23a or 28	ai Director	3501 Howard Park Ave # 229	of. Zip Code 21207	10g. Citizen of What Country? U • S • A •
ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Fur	1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or Ns. specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036 d 2 should be filed within 72 hours alt th and Mental Hygiene. This marked other then "naturel", or traumatic event, Its Medical Examitanumatic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	s Usual Occupation I of work done during most of working NOT use retired)	16b. Kind of Business/Industry Private
	To Be Co	11th Sorte  17. Father's Name (First, Middle, Last) Willie Moore	18. Mother's Name (First, Midd	
C = W L		19a. Informant's Name/Relationship (Type, Print) Barbara Moore – Mother  19b. Mailing A 3501	ddress (Street and Number or Rural Route Num Howard Park Ave #	ber City or Town, State, Zip Code) 229, Baltimore Md 21207
Baltimore, permit. Pages 1 ar Department of Hee importent: if them eny injury or othe	-	21. Signature of Funeral Service Licensee	Cemetery 10-2-2006	20c. Location - City or Town, State  Baltimore, Md  Laughlin Funeral Hom
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	<u>_</u>	arrest, Approximate Interval Between
60, G be executed cien and burial-transit	Examiner		renmence	
\$8760, icate be exemply sicien a physicien a s the burial-	cai	Co. Re	Spiretary fails	nre.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the eltending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		opic pregnancy ner (specify)	23d. Date of delivery  Month Day Year
ds, P	by Pt	Part II. Other significant conditions contributing to death but not resulting in the under		tobacco use contribute to the cause of death?
Cord: w require been sig		Cardio pulmonen ar	rest 10	Yes 2⊠No 3 Probably 4 Unknown
Division of Vital Records, P.O. after deading Physicien: The law requires that the date death. Director After this certificate has been signed by the lin by the funeral director, page 2 should be detached.	Completed	\	24a. We aut	opsy prior to completion of cause of death?
Vita	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	
9 Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Home 5 He	sidence 6 Other (Specify) e how injury occurred
ending F auth. or: After	atio	2 Accident investigation	Work? 1 ☐ Yes 2 ☐ No	
Divis	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death oc 2 ★ Medical Examiner: On the basis of examination and/or invest and manner stated.	gation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
To T To t	2	29b. Signature and title of certifier  TOMOICPELAI, www and a second sec	29c. License number 0 30 1 (5	29d. Date signed (Month, Day, Year)
2			al ct Rd Randellst	rwn mp 21133
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	A. 0	

DHMH 17 Rev 1/2001

				State of Maryland			-	ne	00701
			1 - State Registrar			ate of Death	Reg	ZUUb	32784
	Physici /Medic			rgrove				Day Year	
	Examir	er	4a. Facility Name (If not institution, give	street and number)	4b. Ci	ty, Town, or Location of Deat	h	4c. County of Deat	th
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. last	t birthday) If Und Month	der 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth (Month, Day, You 12 - 3/ - / 9	ear) (Go	thplace (State or Foreign untry)
3	ow #		Usual Residence of Decedent  10a. State  10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
	a-f ehow	ctor	md. N/A	Bai	1 himore	-			1 ∰res 2 □ No
1	a or 28	Dire	10e. Street and Number	ch ant ziv	10f.	Zip Code 2/2/8	10g	Citizen of What Co	A
4	ms 23	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
36	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tyes, Give Year or Dates:		2 No Specify:	o moan, dic.,	Specify: A	
1215-0036	aturei ical E.		15. Decedent's Ec	ducation	16a. Decedent's U	sual Occupation work done during most of wo	16	b. Kind of Business/	A C/C (Industry
121	than "r	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. DO NOT	use retired)	/	onstru	Lan
N	I Hygiene other tha	Be Co	17. Father's Name (First, Middle, Last)		1450	18. Mother's Na	me (First, Middle, Mai		e 17 UH
Maryland	snould be ind Mental s marked o umatic eve	To E		rove		Cledi.	e Somit	h	
Mar	V 60 = 00		19a. Informant's Name/Relationship		19b. Mailing Addre	ess (Street and Number or Re	57 11 1	ity or Town, State, 2	Zip Code)
ore,	of Health of Health filtem 27 r other tr		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Plac	ce of Disposition (f	Name of		c. Location - City or	Town, State
	nent ant: I		4 Donation 5 Other (Specific	y) King		lark 10-13	4-2006 B	alto ha	/. DA
Bal	Department Important eny injury	Ш	21. Signatury of Funera Pervice Licer	Dundan	Car.	He Culluk St	Rolls	led. 21	217
	hysician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications the caused the death. one cause on each line.  M. Hoster  Due to (or as a consequer	ic Lu				Approximate Interval Between Onset and Death
	xaminer		Sequentially list conditions,	b. Lung Ca	encer				<u> 3yvs</u>
9-	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequer	nce org:				V
760,	ite be executed tysician and he burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):				
6876	physic s the b	dlcal	•	d					
Records, P.O. Box 68760, み	inat the death certaicate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at lime of deat 9 ☐ Unknown	eath 3 Ectopic	c pregnancy (specify)		23d. Date of del Month	livery Day Year
Р,	s man t med by e detac	y Ph	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute Id	o the cause of death?
ords	w requires that s been signed to should be det	ted t						2 No 3 P	
Il Records,		Completed by					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita	rnysician: this certificaral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1   Inpatient 2   EF	R/Outpatient 3□	26. Ptace of De	ath (Check only one)	ce 6 Other (Spe	onto)
n of	ng rny fter this neral d	on: To	27. Manner of Death  Natural 5 Pending		8b. Time of Injury	28c. Injury at Work?	28d. Describe how		ony)
Division of Vital	To the Hospitel or Attending Physicien: thin 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 280 Blace of Injury - At hom	M ne, farm, street, fac	1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attantwithin 24 hours after death To the Funerel Director: comptetely filled in by the	cai Ce	29a. Certifier Check only 2 Medical Exa	nysician: To the best of my knowledge: The basis of examination	ledge, death occur	red at the time, date and plaction, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as	s stated. e to the cause(s)
,	ithin 24 to the F omplete	Medicai	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29d	. Date signed (Mont	th, Day, Year)
	- 3 <del>-</del> ŏ		> taul so	smly MD		D1858	7 0	et 14	2006
-	6		30. Name and address of person who	completed use of death (Item 2	23a) (Type, Print)	D1858 Ave 13	m/fina	e mi	71229
Acres		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur		1 /10-	-1 1/18:00	1017	
(6)	Regist	rar	007177	nne I	20	0			

DHMH 17 Rev 1/2001

ORIGINAL

06-07681 James Hall

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

ames Hall	F	I- For State Registrar		ficate of Death	na Menta	, ,	g No. 200	6 3278				
Physician Medical Examine	~	Decedent's Name (First, Middle,Last)  Tomographic  T		11-17		Date of Deat     Month     October 12		3. Time of Death 1735 hrs				
- Lyamma	James Lee  4a. Facility Name (if not institution, give street and number)			Hall  4b. City, Town,	or Location of		4c. County of Death					
		Johns Hopkins Bayview Medical Center		Baltimore								
Funeral Director		218-64-4602 1KM 2F	(In yrs lasi		ear If Under	1.0-	irth(MM/DD/YYYY) 9 Birthplace (State or Foreign Country) MD.					
any	H	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside										
	ا ج		1 Yes 2 XNo									
r death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number 4406 Greencove Circle		10f. Zip Code 21 2		10	og. Citizen of What Cou USA	intry?				
	/ Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	? ( Specify Yes or No- Puerto Rican, etc )									
nours a	g o	15. Decedent's Education (Specify only highest grade com		6a. Decedent's Usual Occup during most of working li			16b. Kind of Business	Industry				
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	Crain Mill			Bethlehem Steel					
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	틹	17. Father's Name (First, Middle, Last)	Maiden Surname)	50001								
1215 l be file ental H arked	Be											
MD 21 nd 2 should b alth and Men m 27 is mar	-1	19a Informant's Name/Relationship (Type, Print )  Dorothy Hall wife		19b. Mailing Address (Str 4406 Greenco	ove Cir	cle, Sparr	ows Point,	ID. 21219				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other transmattic event, the Addical Examiner		20a Method of Disposition  1	. cre	ace of Disposition (Name of dematory or other place)  Ly Hill Memor	rial	October 16,2006	20c. Location - City o	ver, MD				
Balti permit Departn Import injury		21. Superfice of Funeral Service Licensee	>	1 / 110 2011	lers Po	IIIL ROad,	Dundalk,P. Dundalk,MD	A. 21222				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Attercocleratic Cardioveccular Disease.										
Examiner	Ì	or condition resulting in death)  Due to (or as a consequence of):										
	niner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Cause Ener Underlying Cause (Disease or injury that initiated										
760, froate be executed g physician and the burial - transit	Medical Examine	events resulting in death) Last Due to (or as a consequence of):  d.										
be exesician a	gica	UNPENDED										
ox 687 ath certific	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   2   No 9   Unknown   Unknown   2   Unknown   2   Unknown   2   Unknown   2   2   Unknown   2   2   2   2   2   2   2   2   2										
, P.O. Be ires that the de signed by the	P Š	Part II. Other significant conditions contributing to death	but not res	ulting in the underlying caus	e given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?				
ires th	1 Yes 2 No 3 Probably											
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death.  The law requires that the rest and the forestor. After this certificate has been signed by the funeral director, page 2 should be detach.	Completed by						sy prior to med? death?	utopsy findings available completion of cause of es 2 No				
cian:		25. Was case referred to medical examiner? Hospital: 1 Inpatier			Othor	theck only one)						
of Vi	의	1 Yes 2 No 28a. Date of Injur	ry 2	R/Outpatient 3 DOA  28b. Time of Injury 28c. Ir	njury at Work?		Home 5 Residence 6 Other:  8d. Describe how injury occurred					
ending ath.	틸	1 Natural 5 Pending (Month, Day,Ye	ar)	1	Yes 2 N							
Division ital or Attenurs after death al Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Nor Town, State)										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the best of my one)										
T. W. i.v.	Ř	29b. Signature and title of certifier	29d Date signed (Me	(Month, Day, Year)								
		Muss a Drassell of 30. Name and address of person who completed cause of di	eath (Item 2		C.M.E.		October 13, 2006					
4		Melissa Brassell, MD Assistant Medical		,	Baltimore,	MD 21201						
Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar OCT 1 7 2006	's Signature									
DHMH 17 Rev 1/200		The same	J	ORIGINAL								
				CITIOHANE								

			For State	State of Marylan	d / Departi	nent of He icate of D	ealth and N	lental Hygi	ene 006	32786			
			Registrar  1. Decedent's Name (First, Middle, Last)		Certiii	cate of D	eairi	2. Date of Death	g. No.	3. Time of Death			
п	Physici		Vera E1	•			Month	Day Year					
y a	/Medio		4a. Facility Name (If not institution, give s			. City, Town, or Le	ocation of Death	October	4c. County of De				
J.			Gilchrist Cente	r		Towso	on		Ba1t	imore			
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. I	Me	Under 1 Year   I	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)			
	Director		215-28-0298 Usual Residence of Decedent	76	Yrs.			July 18		aryland			
	/land low at		10a. State 10b. County	10c. City	y, Town or Location	n				10d. Inside City Limits			
	a-f sh iffed	ctor	Maryland Baltimo	re	Spa	rks				1 □Yes 2MNo			
	or 28	Director	10e. Street and Number			0f. Zip Code		10	g. Citizen of What	Country?			
	ath w		2 Rainflower Path			2115			USA				
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. Was	Decedent of Hisps, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.			
936	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:	10	Yes 21√2 No	Specify:		Specify:	White			
ဝို	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent	s Usual Occupation	on	ing 1	6b. Kind of Busines				
2	ithin he.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	of work done dur IOT use retired)	ning most of work	nig					
2	lled w Hygiel her ti		12 17. Father's Name ( <i>First, Middle, Last</i> )	01	Mortg	age Assi		e (First, Middle, M	Financi	al			
and	be d all all eve	) Be	James	Emudah t		"		e (FIISt, Middle, M	,	,			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Ţ	19a. Informant's Name/Relationship (Typ	Enright  De. Print)	19b. Mailing Ad	Idress (Street and	Vera d Number or Rur	al Route Number.	O Brien ber, City or Town, State, Zip Code)				
	1 and 2 Health a em 27 is		Harold E. Hoover/	lusband					ks, Maryl				
altimore,	S to E		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pl	Place of Disposition remetery, cremato	(Name of	1	Date 2	Oc. Location - City of				
Ĕ	Pages ment of I		4 Donation 5 Other (Specify)		lley Mem	emorial Gardens   Timonium, Maryland							
Bail	permit. Page Department of Important: If any injury or once.		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc.										
	EL = 60	-	10 W. Padonia Road, Timonium, MD 21093										
L	D1 -1 -		shock, or he art failure. List only on Immediate Cause (Final	e cause on each line.	st C	CALO C.C.	Such as cardiac	or respiratory arres	ы,	Approximate Interval Between Onset and Death			
	Physician / /Medical	-	disease resulting in death) a	Due to (or as a consequ			years						
	Examiner			Dae to for as a consequ									
	D Æ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):								
	ecute and trans	Examiner	that initiated events c. resulting in death) Last										
60,	be ex ician burial			Due to (or as a consequ									
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical	d.										
Box	leath certif attending I for use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregnar		ppicpregnancy			23d. Date of d	elivery			
	death e atte	icia	in the past 12 months? 1 □ Yes 2 A No			Month	Day Year						
J.	at the de by the a stached	Physician/M	9 □ Unknown	9□Unknown		1							
	w requires that been signed to should be deta	Ď	Part II. Other significant conditions con	ributing to death but not resu	ulting in the underl	.J.	23e. Did tobacco use contribute to the c						
0	requi	eted				1   Yes	2 □ No 3 💢 I	Probably 4 □Unknown					
ě	has t	Completed					70	24a. Was an autopsy	prior to	autopsy findings available completion of cause of			
Vital Records,			25. Was case referred to medical				6 Bl / B /	perform 1 Yes 2	No 1 ☐ Ye	s 2 No			
	ysicla s cert directo	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	Other		n (Check only one)	oo e'Mother (Sa	ecify) NOS Píce			
Division or	ding Phys n. After this funeral dii		27. Manner of Death		28b. Time of Injury	28c. Injury at Work?		28d. Describe how		ecity) V (OS por Cap			
000	Attendir death. ctor: Af y the fur	atio	Natural 5 Pending investigation	(mornin, buy roun)	Mijary M		s 2□No						
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, street, f	actory, office			Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physician: within 24 hours after death: "A the Funeral Director: After this certifics completely filled in by the funeral director; p		29a. Certifier 1 Certifying Phys	ician: To the best of my know	wledge death occ	urred at the time	date and place	and due to the cou	social and manner	no otated			
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical Examin	er: On the basis of examinati and manner stated.	tion and/or investi	gation, in my opin	nion, death occur	ed at the time, dat	te and place, and di	ue to the cause(s)			
	within comp	Me	29b. Signature and title of certifier			29c. License no	umber	290	d. Date signed (Mor	nth, Day, Year)			
			Mund			1258	8393	C	CTUBES	14 2006			
	4		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, Print	1. 60	0 4		2.75				
			30. Name and address of person who cor  AMOW Cherelei  31. Date filed (Month per Year) 7 20	MO 6567	IV. CUM	res gr	BATT	nre no	11204				
	Sta Registr	ie ar	20	Ub Service Signat	All Ages	SEL D							

DHMH 17 Rev 1/2001

			For							lental Hygic	•		70707		
		4	1 - State Registrar		,	•		of Dea			No. UU	5	32787		
	Physici	an	1. Decedent's Name (First, Middle	ə, Last)						2. Date of Death Month	Day Y	ear 3	. Time of Death		
	/Medic		Brian	James		Hate				Octobe		006	5120 M		
	Examin	er	4a Facility Name (If not institution	) / / ,	Mlo	1.0.	4b. City, T		ation of Death Burnie		4c. County of		1		
	Funeral	-	5. Social Security Number	ASMULTON 6. Sex 7. A	ge (In yrs.	last birthday)	If Under 1	Year If U	Inder 24 Hrs.	8 Date of Birth	Anne A		L (State or Foreign		
	Director		215-19-3858	10XM 201F	29	Yrs.	Months	Days Ho	ours Min.	(Month, Day, ) Nov.23,	1976	Country) MD			
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					104	Inside City Limits		
	Aaryla I eho	ō	MD Anne An			ern	oution						1 ☐ Yes 2√☐ No		
	28 728	Director	10e. Street and Number				10f. Zip (	Code		100	. Citizen of Wh	at Country?	,		
	Juithin 72 hours after death with the Maryland plan. Jiene. Then "naturel", or Iteme 23s or 28e-f ehow The Medical Examiner must be notified at	a D	8369 W B & A F	Road			21	144			U.S.A				
	-me	Funeral	11. Marital Status	Armed Forces	2. Was Decedent Ever in U.S. 13. \ Armed Forces?			ent of Hispan fy Cuban, Me	ic Origin? (Spenican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black.	American I White, etc.	ndian,		
20	hours after turel', or ite al Examina	by Fu										Specify: White			
5-0036	ture!	ed t	15. Decedent	it's Education		16a. Dece	dent's Usual	Occupation		16	ib. Kind of Busin	. Kind of Business/Industry			
2 <u>1</u> 2	within 72 ene. then "nat he Madic	plet	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-4or	5+)	(Give	kind of work DO NOT use	k doné during a retired)	most of work	ing		ŕ			
N	filed wit Hygiene other the	Completed	10			Plumb	oer					Plumbing			
2	e d it b	Be	17. Father's Name (First, Middle,	Last)						) (First, Middle, Ma	iden Surname)				
Maryiand	hould d Men marke matic	2	Terrill Hatch  19a. Informant's Name/Relationsl	thin (Type Print)		19h Mailie	na Addrace		Sandra	Parker al Route Number, (	City or Town St	ate Zin Co.	del		
<u>S</u>	and 2 s salth an n 27 is i		Mr. Terrill Hat							rn Maryla			06)		
ē,			20a. Method of Disposition		20b. P	Place of Dispo emetery, crei			- (	Date 20	c. Location - Ci		State		
Ē	Pages nent of ant: If It ary or o	-	1 Donation 5 ☐ Other (S <sub>i</sub>		9	n Have			0ct 20		len Bur	nie.	MD		
Baitimore,	permit. Pages Department of I Important: If It eny injury or o		21. Signature of Funeral Service	Licensee	/	22	2. Name and	Address of	Facility Sin	gleton Fu	meral H	Iome.	P.A.		
	40 5 5 a		Man a		M013	57 1	Secon	u Avei	iue sw	Gren buri	ite rib 2	.1001			
Е		shock, or heart failure. List only one cause on each line.											proximate erval Between aset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Weningo once photifis fongal Bueeks  Due to (or as a consequence of):										3 weeks		
П	Examiner														
	n =	ner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury									-1			
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events c												
60,	te be executed ysicien and le burial-transit														
/89	ficate p phys			d											
ROX	eath certificate attending phy I for use as the	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Tectorio pro				23d. Date of	of delivery			
	The law requires that the death certifica site hes been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	in the past 12 months?  1   Yes 2   No 9   Unknown								Month	Month Day Year o use contribute to the cause of death?			
о. О	nat the de d by the a letached	Phy								23e Did toha	cco use contribu				
ds,	uires that signed b	d by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Records,	w requir been si should	lete								24a. Was an	7	re autonsv	findings available		
Ä	sician: The law s certificate hes b irector, page 2 s	Completed								autopsy performe	d? prid	r to comple th? Yes 2⊈	etion of cause of		
Vital		BeC	25. Was case referred to medical	ı [				26.	Place of Deat	1 ☐ Yes 2 ∩ (Check only one)	No 1L	1105 234	J 140		
	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat		ER/Outpatier	nt 3□ DO/	Other: 4		Home 5 Residence 6 □Other (Specify)					
Ĕ	ling P	lon:	27. Manner of Death  1 △ Natural 5 □ Pendin		jury ay Year)	28b. Time o Injury		lc. Injury at Work?		28d. Describe how injury occurred					
Division of	death death ctor: ,	lcat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be 280 Place of Ir	niury - At ho	ome farm str	M reet factory	1 Tes		28f. Location (Street and Number or Rural Route Number,					
<u>^</u>	al or A	Certification:	4 ☐ Homicide determ	building, e	etc. (Specif	y)	.001, 1201019,	311100		City or Town,					
	To the Hospital or Attending Physician: within 24 hours effected ath. To the Funeral Director Atlerthis certific completely filled in by the funeral director.		29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	t of my kno	wledge, deat	h occurred a	t the time, da	ate and place,	and due to the cau	se(s) and mann	er as state	d.		
	To the H within 24 To the F complete	Medical	one)	and manner s	stated.										
1	To With	-	29b. Signature and title of certified	6/0	111	^	290.	License nun	I/ > C		Date signed (		0 6		
	17		30. Name and address of person	who completed cause of	death (Iten		Print\	1 (200	7 0 8 V	ie ilaza i	40	7 /3	1006		
	1		Both ware (	2) achinit	Du.	Med al		Cente	Y 30	1 HOSAH	fal Dr	(-1. i/	Burnie		
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa		- 43 -			0	9.1				
	Registi	ar	OCT 1	7 2006	Poll 1	M. A	Const.	e.00							

			1 - For Stata Ragistrar	State of Mar	ryland	d / Depa <i>Cei</i>	artment tificate	of H	ealth a Death	and M		giene Reg. No		6	327	88
	Physici	an	Decedent's Name (First, Middle, Last)									ath Da	v Y	ear	3. Time of	Death
	Physici /Medio	Joyce Ann Hurst					Octobe	r 12	, 200	6	8:00	a <sup>M</sup>				
١	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Harbor Hospital Center Baltimor							of Death			. County of	Death		
	Constant				(In vrs. la	ast birthday)	If Under		e If Under:	24 Hrs.	8. Date of Bir	N/		Birtho	lace (State or	Foreign
	Funeral Director		1110 LO ((11	□M 2X)F	55	Yrs.	Months	Days	Hours	Min.	Aug 29	y Yar	51 M	lary	Tand	roroigir
	p .		Usual Residence of Decedent		10- 00											
	e Maryle la-f ehov	ctor	MD 105. County N/A	В	alti	, Town or Lo LMOTE	cation							1	0d. Inside Cit 1 X Yes	•
	or 28	Dire	10e. Street and Number				10f. Zip						izen of Wh	at Cour	ntry?	
	s 23e	rai	3902 Fairhaven Ave				2122			1.0.0		U.S			- 6.4	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment or Health and Mental Hygiene. Important: If item 27 is marked other than "nature!, or items 23e or 28e-f ehow with injury or other treumatic event, it a Medical Exeminan must be notified at ODGs.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	erin U.S	'	was Deced f Yes, spec l ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Black, Specify: V	White,	etc.	
2-0	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	lent's Usua kind of won	l Occupa	ition	t of worki	na	16b. K	ind of Busin	ness/Inc	dustry	
21	ithin .	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	)		kind of wor DO NOT us	e retired)	)	O WORK	ng .					
121	filed w Hygien Sthertl		17. Father's Name (First, Middle, Last)			Bar To	ender	1	19 Motho	r's Name	(First, Middle	Liq				
anc	d be feed of	To Be	Ed Dietrich								elious	, Maiden	Sumame)			
ary	should be and Mental marked o umatic eve	F	19a. Informant's Name/Relationship (7	"ype, Print)		19b. Mailir	g Address				l Route Numb	er, City o	or Town, Sta	ate, Zip	Code)	
	and 2 lealth a m 27 to		Ronald Hurst/Husba	and		3902 1	Fairha	aven	Aven	ue C	urtis H	Bay 1	Mary1	and	21225	
Baltimore,	Pages 1 anneal of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		l ce	ace of Dispo emetery, cren t Arun	natony or ot	her niace	itory		ate L6 <b>–</b> 2006		enton,	•		
Balti	permit. Pag Depertment Important: eny injury c		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Signature of Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Address of Facility Ambrose Funeral Home of Lacensee  27. Name and Addr											down.		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Act the Myocard of the Cardiavascular Disease of the Cardiavascular Disease or Cardiavascular Disease or Cardiavascular Disease years  Sequentially list conditions,													
	The law requires that the death certificate be executed by the attending physicien and be been signed by the attending physicien and be detached for use as the burial-transit as a second by the attending burial-transit and be detached for use as the burial-transit and burial-tra	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequ	ence of):	c Co	rd	12V	320	ular	DIE	esse		year	·\$
P.O. Box 6	the death certific y the attending p tched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal	death 3	Ectopic pre						23d. Date o Month		,	ear
	quires thet the de in signed by the a uid be detached f	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in								23e. Did tobacco use contribute to the caus					eath?
Division of Vital Records,	The law requir sete hes been si page 2 should	Completed									24a. Was autor perfo	an osy ormed? 28 No	sy prior to completion of caus med? death?			vailable use of
/ita	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne				
on of	ding Phys n. After this funeral di	tion: To	27. Manner of Death  1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Unitary at Work?  M 1 Yes 2 No					2	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred						
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funerei Director: A completely filled in by the fu	Certification;	2						28f. Location (Street and Number or Rural Route Number, City or Town, State)					e <i>r</i> ,		
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	ledical C	29a. Certifier Check only one) Certifying Ph	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the									ated. the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier			,44	29c.	License	number			29d. Da	te signed (/	Month, l	Day, Year)	
	/		A4h	nding Ph	745	10161		DS.	185	3		00-	to50,	1:	3.20	06
	1		30. Name any address of person who	completed cause of dea	ith (Item	23a) (Type,	Print)	SAI	12/	B	ultin	01.	e	2	-1229	5
,	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 7 2	32. Registrar	s Signati	ure	raile)	,								

			1- State of Maryland / Dep Registrar Ce	artment of Health and Me	ntal Hygier	2006 32789
m	Physici	an	Decedent's Name (First, Middle, Last)			3. Time of Death
	/Medic	al	Irene Rita Helvig	4b. City, Town, or Location of Death		12,2006 12:15 P M 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)  LEVINDIFIE	BALTIMORE		BALTIMORE CITY
5	Funeral		Social Security Number     6. Sex	) If Under 1 Year If Under 24 Hrs. 8	. Date of Birth	9. Birthplace (State or Foreign
1	Director		193-10-0320	J1	ul. 21,	1923 Pennsylvania
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits
	Mary a-f sh	to	MD N/A	Baltimore		1 Yes 2 No
	or 28	Oire	10e. Street and Number	10f. Zip Code	_	Citizen of What Country?
	• 23a	ra	2434 Belvedere  11 Marital Status 12. Was Decedent Ever in U.S. 13.	21215		United States  14. Race - American Indian,
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other then "natural", or iteme 23s or 28s-f show marked other then "natural", or liteme 21s or 28s-f show maric event, the Marylan Examinar matal be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Rice  1 ☐ Yes 2 ☒ No Specify:	can, etc.)	Black, White, etc.  Specify: White
<u> </u>	72 hou	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	16b.	Kind of Business/Industry
2	hen "	m ple	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of working DO NOT use retired) Homemaker		Ora Hama
N D	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (/	First, Middle, Maide	Own Home
		To Be	Sigismund Zakrzewski	Stella M	akarewicz	Z
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked eny Injury or other traumatic ev <u>once</u> .		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural F	Route Number, City	y or Town, State, Zip Code)
e ດົ	tand teelth om 27 her tr		Virginia Knauff - Daughter 130 20a. Method of Disposition 20b. Place of Disp	07 Ridge Road, Cator		MD 21228 Location - City or Town, State
000	ages of hot of h		X Burial 2 Cremation 3 Removal from State	Cemetery 10-17-2		oodlawn, Maryland
Baltimore,	nit. Partme cortani Injury	1		2. Name and Address of Facility Amil 1		
Ď	Deg a mag	1	Colling College MOTON	1328 Sulphur Spring	Rd., Art	outus, MD 21227
	- Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac or r HEMORRHADE	respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	3n V	ē	Sequentially list conditions, if any, learning to infinediate cause. Enter Underlying Cause (Disease or injury			
	cuted nd ransit	Examiner	that initiated events C.			
8760,	cate be executed obysicien and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
687	physicate to physical street.	dlcal	d			
Box	death certifica attending ph d for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med		Other (specify)		Month Day Year
Р.О	res that the igned by be detact	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	w requires been sign should be	ed by	HYPERTENSION		1 🗆 Yes	2 No 3 Probably 4 Unknown
eco	law requase been 2 should	Completed	DEMENTIA		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E .	the cate has	Con			performed?	? death?
Vita	certification	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (		
ō	Attending Physicien: r death. ector: After this certifics by the funeral director, i	. To	27. Manner of Death 28a. Date of Injury 28b. Time (		d. Describe how in	
Ö	ath. r: Afte	atlor	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No		
Division of Vital Records,	2 th = -	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office 28	f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
)	To the Hospital of within 24 hours after To the Funerel D completely filled in	Medical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
1			beim it unstation	10063327	10	1/12/2006
5	)		30. Name and address of person who completed cause of death (Item 23a) (Type GIZAW LYDLDEHIWOT 2434 WEST	BELVEDERE AVE	E BALTI	IMDRE, MA 21215
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	had s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
17	Regist	rar	UCT 1 7 2000 Marin 13. 1	103942		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 006 32790 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14:58 PM 2006 October .3, James Francis Herold, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday)

Age (In yrs. last birthday)

Yrs.

The property of the propert Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 15€M 2□F 1944 Maryland Director 213-44-7661 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location or 28a-f ehow item 27 is marked other then "natural", or iteme 23a or 28a-1 ebov other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Maryland Edgewood Harford Director 10g. Citizen of What Country? 10f. Zip Code 21040 10e. Street and Number USA 603 Wingleaf Court Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 25 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Chemical Manufacturer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be family and Mental F Ruth Lena Bosie Herold, Francis James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is rr eny injury or other traum once. 603 Wingleaf Court, Edgewood, Maryland Barbara Jean Herold - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 200. Place of Disposition (Name of Commission)

Linion Chapel Meth.

Church Cemetery 10/20/2006 Joppa, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nemana **Physician** /Medical Due to (or as a consequ ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part I δ 1 Ves 2 □ No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of palson who completed cause of death (Item 23a) (Type, Print OO U 32 Aegistrar's Signature 31. Date filed (Month, State Registrar

		1	For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of He tificate of D		ntal Hygier <sub>Reg. ۱</sub>	ZUUb	32791
	o		Decedent's Name (First, Middle, La.	st)			2.	Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic	al .	Billy Lee Hagy					ictobu	7 2000	<u> </u>
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or L	Location of Death	'	4c. County of Death HARFO	
			LORIEN © 1 5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year		Date of Birth	9. Birtl	nolace (State or Foreign
1	Funeral Director			<b>∑</b> M 2□F	63 Yrs.	Months Days	Hours Min.	(Month, Day, Yee ec. 14,	'	intry) ryland
	D		Usual Residence of Decedent		10c. City, Town or Lo	ontion				10d. Inside City Limits
	show	_	10a. State 10b. County  Maryland Harfor	a	Forest					1 ☐ Yes 2 X No
	death with the Maryland ms 23a or 28e-f show Frittet be codified at	Director	10e, Street and Number	<u> </u>	rolest	10f. Zip Code		10g.	Citizen of What Co	untry?
	with With		2424 Johnson Mil	1 pd		21050	0		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His	panic Origin? (Specif , Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, White	
ي و	or ite		1 Never Married 2 Married	1 ⊟Yes 2X	No	1 ☐ Yes 2√€ No	Specify:	an, 5.60.7		
203	filed within 72 hours after Hygiene. ther than "natural", or Ite int, the Medical Examins	d by	3 Widowed 4 Divorced	Yeer or Dates:			41	106	. Kind of Business/	ite
15	"nati	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of working	100	. Killid of business	ridustry
12	withii lene. than	mo	Elementary/Secondary (0-12)	College (1-4or	Tru	ck Driver		Co	mmercial	
b	be filed ital Hyg id other event,	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Name (F	First, Middle, Maid	den Sumame)	
/lar	should by ind Menta s marked umatic ev	ToE	George Lee Hagy				Flora Ma			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If main 27 Is marked other than "natural", or items 23a or 28e-1 show other traumatic event, I'm Medical Examiner must be notified at		19a. Informant's Name/Relationship			-	nd Number or Rural F			lip Code)
	l and lealth Im 27	1	Sherry Keithley/ 20a. Method of Disposition	Daugnter	12U8		d., Street		Location - City or	Town, State
altimore,	0 0		1 Burial 2 Cremation 3		cemetery, cre	matory or other place	1	0.0		
菲	permit. Pag Department Importent: I any injury o	. 4	'4 ☐ Donation 5 ☐ Other (Special Signature of Finer) Service Lice		Hilltop S		rp.: 10-16 <sup>s of</sup> McComas		vson, Mar	
Ba	permit. Departr Import		Mulb (1	most			bury Rd.,			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each !	d the death. Do not en					Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition			iner di	/ec\s			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consiquence of):	7140	,,,,,			
	Examiner	L	Sequentially list conditions,	b. Due to /or as	a consequence of):				_	
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (0) as	a consequence or,					
	and and al-tra	Exar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of);					
8760,	cate be executed physician and the burial-transit	dical	(	d						
9	as as	Medi	IF FEMALE:							
30X	ath certif attending for use as	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	ivery Day Year
0.	the a	ysic	1 Yes 2 No	4∐Pregnant a 9□ Unknown	it time of death 5	Other (specify)				
ď.	es that the death certifi igned by the attending be detached for use as	by Physiclan/Me	Part II. Other significent conditions	contributing to death	but not resulting in the u	ınderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	luires n sign uld be		Hyperter	via chi	anic chity	echer who	kry dirane	1 🗌 Yes	2 No 3 P	obably 4 Unknown
OS	s been s	olete	Prodor a	the chine of	enir chifr		· ·	24a. Was an autopsy	24b. Were at	stopsy findings available completion of cause of
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certifinr death. ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	Completed		17.07.				performed	death?	2□ No
ita	sien: ertifica ctor, I	Be	25. Was case referred to medical examiner?			04	26. Place of Death (			
of V	Jing Phyeicien:  After this certific funeral director,	ပု	1 Yes 2 30	Hospital: 1 Inpat			4 Nursing Home	5 Residence	e 6 Other (Spe	cify)
uc	ding F	lon	27. Manner of Death  1 Ratural 5 Pending investigati	(Month, D		Work	(? Yes 2 □No	a. 50001100 11011	,,	
/isi	after death after death Director:	fica	3 Suicide 6 Could not	be 28e Place of Ir	njury - At home, farm, s	reet, factory, office	28	I. Location (Stree City or Town, S	et and Number or R	ural Route Number,
Dİ	를 를 들	Certification:	4  Homicide	bullding, e	tc. (Specify)			011) 01 7 0471, 0		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying F	hysician: To the bes	t of my knowledge, dea of examination and/or i	th occurred at the tim	ne, date and place, an pinion, death occurred	d due to the caus I at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	the hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner s	tated.	29c. License			Date signed (Moni	
	or Wit	-	255. Signature and title of certifier	Mari	(.	0	7975		white	
	2		30. Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)	(1/1	(	0/11/0	t
	2		A RUD	Mcary	m 61:	- Mac/	mil 1d	Shell	AIV. MY	21014
		ate	31. Date filed (Month, Day, Year)	2006 32. Flegis	trar's Signature	Carles		,		
	Regist	rar	66 4	LOUD FOR	which was the first					

#### Please Type or Print in Black Indelible Ink

Larry Thomas Hai		l- For State Registrar		of Maryland		rtment of tificate of		d Mental H		eg. No. 200	16 3279
Physiciar Medical Examina		1. Decedent's Name Larry		Thomas	<del></del>	Hart	csock		Date of Dea     Month     October 1	Day Year	3. Time of Death 1252 hrs
			f not institution, gi	ve street and number	er)	4	b. City, Town, or I	Location of Death		4c. County of De	
Funeral	- 1	5. Social Security N	lumber 6. S		Age (In yrs. Ia	st birthday)	If Under 1 Year		_	Baltimore C	
Director	L	217-92-04 Usual Residence of		XM 2 F	4	3 Yrs.	Months Days	Hours Min	Septemb		Country) Maryland
w any	ſ	10a. State	10b. County			Town or Location					10d. Inside City Limits
ne Maryland or 28a-f show any fied at once.		Maryland   10e. Street and Nur	Baltim	ore	Sp	arrows	Point  10f. Zip Code		- T <sub>1</sub>	0g Citizen of What C	1 Yes 2 XNo
the Ma	함   조	2511 N. S		enue			212	19		USA	Sanay.
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene, and the filed with a marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marrie	ed 2 Marrie	d Armed Force			s Decedent of Hisp es, specify Cuban,			14. Race - An White, etc	nerican Indian, 8lack,
s after c	ᇗ	3 Widowed		d If Yes, Give Year or Dates:			Yes 21 No			and the second second	Mite
72 hour n "natu	ered	Elementary/Seco		College (1-4 o			's Usual Occupations of working life.			16b. Kind of Busines	;s/industry
within giene.	ᇍ	10 years 17 Father's Name (	(Eiret Middle Lae	*)		Carp	enter	IS Mothor's Name	/First Middle	Shipyard	<u> </u>
215- be filed ntal Hyg rked of	음 기	John Hart		ı				Patrici	a Riley		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiers han Important: If them 27 is marked other than injury or other traumatic event, the Medica	- [	19a. Informant's Na Joyce Har		Type, Print ) <b>Wif</b>	e	1				nber, City or Town, St	ate, Zip Code) , MD. 21219
Baltimore, MC pernit Pages I and 2 si Department of Health at Important: If fiten 27 injury or other trauma		20a. Method of Disp	position	Removal from	20b. P	1	tion (Name of cerr		pate ober	20c Location - City	·
ti Pages tment of rfant: 1		4 Donation 5	Other Specif	y: ,		view Cr	rematory	16	, 2006		City, MD.
Bal permi Depar Impor	(	Intho	neral Service Lice	ounce	ler	711	melly Fu 0 Solle:	ineral H rs Point	ome Of Road,	Dundalk, P Dundalk,MD	P.A. D. 21222
Physician /Medical		failure. List onl	ly one cause on e		1	Do not enter th	e mode of dying,	such as cardiac o	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (I or condition resulting		Methadone  Due to (or as a cor							- Bodin
		Sequentially list cor if any, leading to im cause. Enter Unde	mediate	Due to (or as a cor	nsequence of)	K:					<del> </del>
d sit	Examiner	(Disease or injury to events resulting in	nat initiated	Due to (or as a cor	sequence of)	:					
cath certificate be executed attending physician and for use as the burial - transit	Medical	X UNPENDED			3a 27 28	Ra—f nor	ME,g860, 1		т		
760, icate be physici the buri		IF FEMALE:	pregnant in the	23c. If yes, outc						23d Date of deliv	ery
x 68 th certif ttending	Physician	past 12 months	?	_ 1 =	at time of dea	th =	aldeath 3 ner (Specify)	Ectopic pregna	ancy	Month	Day Year
D. Bc trthe dea by the a ached fo		1 Yes 2 N		9 Unknown	ath but not re	sulting in the u	nderlying cause gi	iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
S, P.O. E lires that the d signed by the d be detached	[			· · · · · · · · · · · · · · · · · · ·				<u>.</u>	1 Yes	8 2 No 3 P	robably 4 🗸 Unknown
Cord law requas been as peen that been that the conditions are the con	Completed			<del></del>					24a. Was autop perfo		autopsy findings available o completion of cause of
II Re In: The retificate for, page		25. Was case referr	red to medical				26.Place	of Death (Check	1 V Yes		
F Vita	8		2 No			ER/Outpatient				Residence 6 🗸 Ott	ner: Scene
on o anding ath		27. Manner of Death  1 Natural	5 Pending	28a. Date of Ir (Month, Day	/,Year)	28b. Time of In		y at Work? es 2 , No		how injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	Certification:	2 Accident 3 Suicide	Investiga 6 X Could no determine	t be 28e. Place of	Injury - At hor	Fnd 12:4 me, farm, stree	o all l t, factory, office bu	A uilding, etc.	28f. Location (S or Town, S	Street and Number or State) 2511 N. S	Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		4 Homicide 29a. Certifier (Check only 1		(0)00)	House my knowledge	e, death occurr	ed at the time, dat	te and place, and		State) 2511 N. S , MD se(s) and manner as si	
To the within To the comple	ᄝᆚ			er:On the basis of ex and manner state		d/or investigati	on, in my opinion, 29c. License		at the time, date	and place, and due to	
		Downski	Gynthan	ul ma			O.C.N			29d Date signed (f	
7	f			completed cause of			L Dame Ci	D-W	4D 04054		
Sta	te	Pamela E. S 31. Date filed (Mont		Assistant Me	dical Exan		Penn Street	, Baltimore, N	лD 21201		
Registra		(	OCT 1 7	2006	Billian 1	11 100	and s				

State of Maryland / Department of Health and Mental Hygiene 005 32793

		•	State Registrar		-	Cer	tificate of	Death	7	,	Reg. No	2000	521	
	9 - 19 - 19 - 19 - 19 - 19 - 19 - 19 -		1. Decedent's Name (First, Middle, Las	st)					2	. Date of De			3. Time of	Death
	Physici /Media		Evangelin	a Herrera					0	ctobe	r 13	2006	2:26	A M
	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location	of Death		40	. County of Death	ı	
	\$		Suburban Hospita					esda				Montgom	ery	
	Funeral		5. Social Security Number 6. S	□M 2177F	-	st birthday)	If Under 1 Year Months Days	If Unde Hours	Min.	Date of Bi (Month, D	ay, Year,	) Cou	place (State o untry)	r Foreign
	Director		377502-4241	8	6	Yrs.			0	ctobe	r 18,	1919 Bol	lvia	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside Cit	ity Limits
	Aaryl F sho ed al	ŏ	Manual Manuary		n	. 4-1	1 .						1 ☐ Yes	
	the N	Director	Maryland Montgor	nery		etheso	10f. Zip Code				10a Ci	tizen of What Cou	intry?	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		6530 Democracy B	1.74			208	17					nicry:	
	ns 20 mus	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S	3. 13. V			rigin? (Specif	v Yes or No		livia 14. Race - Amer	ican Indian.	
10	r iten	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 No			Vas Decedent of F Yes, specify Cub					Black, White		
936	urs a	þ	3 ☐ Widowed 4 K Divorced	If Yes, Give Year or Dates:		1	X Yes 2□ No	Specify	Bol:	ivian		Specify: W	hite	
Õ	2 hor	Completed	15. Decedent's Ed	lucation	Ţ	16a. Deced	ent's Usual Occup	ation			16b. K	(ind of Business/I	ndustry	
31	hin 7 e. an "r Med	ed l	(Specify only highest gra	College (1-4or 5+)		life. D	kind of work done O NOT use retire	during mo d)	ist of working					
2	ygien gerth the	5	12			Н	omemaker	-				Own Home		
P	al Hy	Be (	17. Father's Name (First, Middle, Last)					18. Moth	ner's Name (F	First, Middle	, Maidei	n Surname)		
<u>/a</u>	Ment Ment	횬	Damian Herrera						Tomas	a Dom:	ingu	ez		
al)	2 should be filed within 72 hours after death with the Marylan and Mental Hygtene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show arumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (3									or Town, State, Z		
≥	and salth n 27		Eva Gabriela Wilc	ox / Daught					Bethe	sda,	Mary	71and 208	317	
ore	of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Romoval from State	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other pla	ce)	Octob	er	20c. L	ocation - City or T	own, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked. any Injury or other traumatic ev once.		4 □ Donation 5 □ Other (Specifi		Monte	gomery C	rematorium	, Inc			Bet	hesda, M	larylan	d
att	partriports		21. Signature of Funeral Service Licer	isee /	,	Pol-	Name and Addre	ss of Faci	lity	1 Ucma /	Path	anda Charr	Chana	Too
ω	99 5 8 9		Ungeletta (San	mst M	0130	5 755	7 Wisconsi	in Ave	nue, Bet	hesda,	Mary	esda-Chevy 71and 2081	4-3501	LIIC.
100			23a. Part1. 5 ter the disease, or com shock, r heart failure. List only	plications that caused the	ne death.								Approximate Interval Bet	е
	Physician		Immediate Cause (Final disease or condition				t Failur						Onset and D	Death
	/Medical		resulting in death)	Due to (or as a			- 101101						rears	
6	Examiner		Opposation link and distance	Aorti	c Ste	enosis							Years	
- 1	E INC.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a										
h	nd	Examiner	Cause (Disease or injury that initiated events	C			myopathy						Years	
Ó,	e exe		resulting in death) Last	Due to (or as a	conseque	ence of):								
68760,	ate b nysic he bu	ica		d										
1) 8	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transity.	Medical	IF FEMALE:								T			
1√(0 Bo)	ath ce ttend or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pt 1 ☐ Live birth 2		death 3∐	Ectopic pregnanc	y				23d. Date of define Month		Voer
Jo	he de	sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of de	ath 5□	Other (specify)					MOULL	Day Y	Year
(7) <b>G</b>	The awkequires that the death of the second to the second to the second age 2 should be detached for us	Physician				Alas Is Absorb	4-4-4			00 - Did				
GE CIS, P.	res th	þ	Part II. Other significant conditions of Pneumonia	ontributing to death but	not resul	ting in the un	derlying cause giv	en in Part	1.			use contribute to		
3ecord	whequir been si should	Completed by	1 HOUMOHAG							1 1	Yes 2	No 3 Pro	bably 4 LC	Jnknown
200	hes by	ple								24a. Was	an DSV	24b. Were aut	opsy findings a	available ause of
		9								perf 1∐ Yes	psy ormed? 2 X No	I death?		
	certificate rector, pag	Be	25. Was case referred to medical examiner?						ce of Death (0	Check only	one)			
30	his co	P	1 ☐ Yes 2X No	Hospital: 1 🔀 Inpatient	2 🗆 E	R/Outpatient		401	lursing Home	5 □ Res	idence	6 ☐Other (Spec	ify)	
3 =	Attending Physician: The rotesth. ect r: After this certificate hay the funeral director, page	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injui Wor	ry at rk?	280	d. Describe	how inju	iry occurred		
RE R ivision	E # : 0	satio	2 ☐ Accident investigation					Yes 2	No					
Z ;∑′	after des Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.	y - At hon <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f	Location ( City or To	Street ai wn, Stat	nd Number or Rui e)	al Route Num	ber,
外記	pital ours at tilled i		W											
7E	Hos Hos Fune Fune tely f	Medical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	examinati	rledge, death on and/or inv	occurred at the ti restigation, in my	me, date a opinion, de	and place, an eath occurred	d due to the at the time	cause(s , date an	s) and manner as nd place, and due	stated. to the cause(s	3)
7 2	To the Hos within 24 ho To the Fun completely	Med	one) 29b. Signature and title of certifier	and manner state	ea.		29c. Licens	se number			20d Da	ato signed /Month	Day Voorl	
	<b>7</b> ≥ <b>7</b> 8			Davis	0 -	(		4150				ate signed (Month		
	Λ		rivancy	Laver	100	12		4170	/		UCE	ober 13,		
	3		30. Name and address of person who		,		•	NT Y	7 77	1. 2		D C 200	016	
			Nancy Davenport, 31. Date filed (Month, Day, Year)	M.D. 33UI  32. Registrar				, N.V	v., Was	sningt	on,	D.C. 200	010	
	Sta Regista		31. Date filed (Month, Day, rear)	nns Sz. regisitat	o orginali	de A	me							
			UUIII	SOUTH THE STATE OF	Services and	3								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland		artment of H rtificate of L				giene Reg. No.	006	32794
	Dhysisi	on	1. Decedent's Name (First, Middle, L.	ast)						2. Date of De	ath Day	Yeer	3. Time of Death
	Physici /Medio		Marvel Fr	ances Hess	·					Octobe:	10,	2006	1:52 A <sup>M</sup>
н	Examir	er	4a. Facility Name (If not institution, gi		)		4b. City, Town, or				4c. C	ounty of Death	
			Holy Cross Ho  5. Social Security Number 6.		ge (In yrs. las	et histholey	S1.		Spri	407			gomery
ı	Funeral Director			1□M 21 F	go (m yrs. ras	Yrs.	Months Days	Hours	Min.	8. Date of Bin (Month, Da October		9. 600 2006 Ma	place (State or Foreign intry) ryland
	pu 👪		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	vantion						40d Inside City Limite
	anyla	ō	,	am a <b>m</b> vv	Toc. City,	TOWN OF LC		<b>.</b>					10d. Inside City Lîmits 1 ☐ Yes 2 図 No
	28a-i	ect	Maryland Montg	omery	<u> </u>		Silver Sp	or rug		<del></del>	10a Citiza	n of What Cou	
	3e or	Funeral Director	13613 Sir Thomas	s Wav #11			2090	)4				ed Sta	·
	death ms 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		igin? (Spe	cify Yes or No		. Race - Ameri	can Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Evanting must be notified at ORGE.	þ	1 점 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 점 If Yes, Give Year or Dates:	No		f Yes, specify Cubai 1 ☐ Yes 2점 No	n, Mexica Specify:		Rican, etc.)		Black, White, pecify: Wh:	
S S	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	lent's Usual Occupa kind of work done d	ition	at of workin	10	16b. Kind	of Business/Ir	ndustry
2121	vithin ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired,	)	K OF WORKE	'y			
N D	illed v Hygie ther t nt, in	ပိ	17. Father's Name (First, Middle, Las	t)			None		er's Name	(First, Middle,	Maidan Su	None	9
aryland	d be ental ced o	To Be	James Dav					10. 1410(11		a Gayl		,	
3	shoul nd Mi mari	F	19a. Informant's Name/Relationship		- 1	19b. Mailir	ng Address (Street a	nd Numb					Code) 20904
>	alth a alth a 27 is		Laura Gayle Hes	s/Mother			Sir Thom						
altimore,	es 1 a of He of He fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 [	Domewal from State	20b. Plac	e of Dispo	sition (Name of	1	Di	er 16,		tion - City or To	
Ĕ	Page ment ant: I		'4 □Donation 5 □Other (Speci		'	Montemato	natory or other place Somery Tium, Inc		200		Beth	esda, N	faryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lie	hsee	M014	73	Name and Address	s of Facili	v Robe	rt A. O West	Pumph Mont -2805	rey Fui gomery	neral Home/ Avenue,
			23a. Part1. Enter the disease, of conshock, or heart failure. Lift only	plications that cause									Approximate Interval Between
B	Priysician		Immediate Cause (Final disease or condition		enceph	alus							Onset and Death 13 Minutes
	/Medical Examiner		resulting in death)	a	a consequer								
	Lxaiiiiiei	٠,	Sequentially list conditions, if any, leading to immediate	b									
10	ted	nine	Cause. Enter Underlying	Due to (or as	a consequer	nce of):							
Ž	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequer	nce of):		<del></del>					
68760	te be ysicia ie buri	edicai	(	_ d									
_	- 70 m		IF FEMALE:										
Box	death certifi e attending id for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal de	eath 3	Ectopic pregnancy				23d	d. Date of delive Month	*
0.0	0 0	Physician/M	1 ☐ Yes 2 ဩ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of deat	th 5	Other (specify)					MOTILIT	Day Year
	ires that the de signed by the a I be detached i	Ph	Part II. Other significant conditions	contributing to death b	out not resulting	ng in the ur	derlying cause give	n in Part I.		23e. Did to	bacco use	contribute to the	ne cause of death?
Vital Records,	law requires that the as been signed by th 2 should be detache	ed by								1 🗆 Y	es 2XXIN	No 3 □ Prob	ably 4 Unknown
ပ္တ	law requir as been si 2 should t	Completed								24a. Was a	an 2	24b. Were auto	psy findings available
ž	0 = 0	mo								autop: perfor	med?	prior to con death? 1 🔲 Yes	psy findings available mpletion of cause of
<u> </u>	sicien: The certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or		7,5,103	20110
> 0	Physicien: this certificaral director,	2	1 ☐ Yes 2 🖾 No	Hospital: 1X Inpatio		VOutpatien	t 3□ DOA Cthe	r: 4 □ Nu	rsing Hom	e 5 ☐ Resid	ence 6	Other (Specif	y)
	ing Yfter une	inol.	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28 iy Year)	3b. Time of Injury	28c. Injury Work			Bd. Describe h	ow injury of	ccurred	
Division	e te e	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	99 Place of In	iuny - At home	a farm etre	M 1 ☐ Y	es 2 🔲		Rf Location (S	treat and N	lumber or Pura	il Route Number.
≥	al or A after after Direction	Certification:	4 Homicide determined	building, et	c. (Specify)	J, 141111, 3116	ot, factory, office			City or Tow	n. State)	omber of riora	r Houle Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director. / completely filled in by the f	edical C	29a. Certifier (Check only one)	nysician: To the best	f examination	edge, death	occurred at the time estigation, in my opi	e, date an inion, dea	d place, ar th occurred	nd due to the c	ause(s) and ate and pla	d manner as st	rated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	u.ou.		29c. License	number		2	9d. Date si	igned (Month,	Day, Year)
	⊢ s ⊢ ŏ		1 Comin	Rent	m L	0	- DN72	1936	5			er 13,	
	K.	1	30. Name and address person who			Ba) (Type, f		1730.	,	1	,	EL 13,	2000
_	リ		Corliss Newhouse,					lver	Spri	ng, Mai	yland	20910	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Э							
	Registr	ar	OCT 1 7 2	006	. A		Ball 3						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 32795 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** Sylvia L. Jones 8:4514 10 12 2006 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner University Specially Hospital Maltimure 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 ☐XF Yrs. 59 Director 216-50-3628 MARYLAND Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Directo MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1038 N BENTLOU STREET 21216 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Maritei Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 ☐ Widowed 4 1 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNIV OF MARYLAND HOUSEKEEPING 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) AUGUSTA GROSS WARE RAYMOND WARE JR. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Ernest B. Jones III/Son 1 L. Jillway Ct., Baltimore, Maryland 21221 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10-18-06 GLEN BURNIE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNTIY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1206 W NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ♣ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? has 2X No this certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Naturel 1 Tyes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D34974 Mentari? 2006

Registrar

State

601 South

32 Registrer's Signature

charles Stroet, Bultimore, MD 21730

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MEMTA,

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () () 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 2006 Jones Ann 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)

Dundalk

32796

3. Time of Death

5:10 P M

Baltimore

Physician
/Medical
Examiner
LAGITITICI

1970 Searles Road

**Funeral** Director

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

ed by the attending physicien end detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	5. Social Security Number 212–28–0003	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I	ast birthday) Yrs.	Months .	Days	Hours	Min.	8. Date of B (Month, D July	Day, Year,	) (	inthplace (State of Foreign Country) ryland
	Usual Residence of Decedent		10a Cib	. Town or Lo	ation						,	10d. Inside City Limits
	10a. State 10b. County  Maryland Balt:	imore	Toc. City	, Town or Loc Dunda								1 ☐ Yes 21 No
	10e. Street and Number 1970 Searles Roa	ad			10f. Zi	212	22			10g. C	itizen of What ( USA	Country?
	11. Marital Status 1 □ Never Married 2 □ Marrie	Amed Fo	2 🔽 No						ecify Yes or N Rican, etc.)	10-	14. Race - Ar Black, Wi Specify: W	
2 2	3 ☑ Widowed 4 ☐ Divorced  15. Decedent'	Year or D	VO	16a Deced	I □ Yes ent's Usu	ial Occur	Specify			16b. l	Kind of Busines	
2	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (			kind of w DO NOT ( tres:		during mo: d)	st of work	ang	Re	estaura	nt
3	12 Years 17. Father's Name (First, Middle, L	acti		Wal	CLES	3	18. Moth	er's Nam	e (First, Midd	le. Maide	n Sumame)	
	Howard F. Buckle						M	ary	Olive I	McSwa	ain	
2	19a. Informant's Name/Relationsh Richard Jones		son						k, MD.	nber, City	or Town, State	e, Zip Code)
	20a. Method of Disposition 1 □ Purial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from	State Mea	lace of Dispo emetery, crem dowrid	sition (Na natory or Ige M	ame of other pla emor	ial	Octo 200	ber 18	,	_ocation - City ethorpe	or Town, State , Maryland
	21. Signature of Funeral Service I		n no b	1112	onne 110	ng Addre	funer ers P	ят н	ome Of	Dung	dalk,P. dalk,MD	A. 21222
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat each line.	h. Do not ent	er the mo	de of dy	ng, such a	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	- M	ENOCAN (or as a conseq		A Z	EFT	MAZ	1166	A ANI)	ALA,	E	18 MONTH
Evaluation	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq									
Pnysician/medical	IF FEMALE:	d	utcome of pregna	ancy							23d. Date of	delivery
iysician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	birth 2 ☐ Feta nant at time of c	Ideath 3	⊒Ectopic ] Other (s		у			-	Month	Day Year
ered by Pr	Part II. Other significant condition	ons contributing to	death but not res	culting in the u	nderlying	cause gi	ven in Part	I,		d tobacco		e to the cause of death?  Probably 4 Unknown
Complete												
ø	25. Was case referred to medical						26. Plac	e of Dea	th (Check on			
ņ	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ 0	OOA O	her: 4 🗆 N	lursina H	lome 5 A R	sidence	6 □Other (S	Specify)
on ; non	27. Manner of Oeath  1 Natural 5 Pendin	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o Injury		28c. Inju					jury occurred	
Medical Certification;	2 Accident investig	not be 28e. Plac	ce of Injury - At h ding, etc. (Speci			ory, office				n (Street Town, Sta		r Rural Route Number,
dical C	29a. Certifier 12 Certifyir (Check only one) 14 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kn basis of examina inner stated.	owledge, deat ation and/or in	th occurre	ed at the ton, in my	me, date a	and place eath occu	, and due to t	he cause ne, date a	(s) and manne and place, and	r as stated. due to the cause(s)
Š	29b. Signature and title of certifie	r					se numbe					onth, Dey, Year)
	My Non	under a	17			72	813	3		10	116/0	21257
_	30. Name and address of person	who completed ca AUNDER	se of death (Ite	m 23a) (Type,	Print)	URS	57	- 1	MANN	one	MA	21207

State Registrar

31. Date filed (Month, Day, Year) OCT 1 7 2

			1 - For State Registrar	State of M	larylan	id / Depa	artment rtificate	of He	ealth a	and M	lental Hyg	ienez ()	06	327	197
	Physici	an	Decedent's Name (First, Middle,  DORA M. KOLI								2. Date of Deat Octobe		2006	3. Time of 12:4	
	/Medio		4a. Facility Name (If not institution,		")		4b. City, To	wn, or L	ocation o			4c. County		12.4	O A
	Exami		12000 Tralee	Road Unit	202		Ti	mon	ium			Bal	timo:	re	
	Funeral Director		217-18-3640	3. Sex 7. A 1 □ M <b>2</b> □ F	ge (In yrs. 83	last birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan. 20	.1923	9. Birthp Cour West	olace (State of htry) Virgi	
	land wo		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside Cit	ty Limits
	Mary	tor	MD Balt	imore		Ti	monium	l						1 🗌 Yes	2 <b>X</b> No
	with the	Funeral Director	10e. Street and Number 12000 Tralee Roa	od IIni+ 202			10f. Zip C	ode 21(	203		1	0g. Citizen of V		ntry?	
	ne 234	eral	11. Marital Status	12. Was Deceden		.S. 13. 1	Was Deceder			gin? (Spe	cify Yes or No-	14. Rac	oA se - Americ	an Indian,	
036	d within 72 hours after death with the Maryland Jene. rr then "neturel", or iteme 23a or 28a-1 ehow the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Marrie	Armed Forces  d 1  Yes 2  If Yes, Give Year or Dates:	) No		If Yes, specify 1 ☐ Yes 2X	Cuban,	Mexican, Specify:	, Puerto I	Rićan, etc.)	Specify Specify	ck, White, y: Wh:	etc. ite	
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual (	Occupati done du	ion ing most	of working	ng	16b. Kind of B	usiness/Inc	dustry	
Maryland 21215-0036	l within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	1	kind of work DO NOT use rds De	part	ment	· -		MVA			
and	ed is b	Be	17. Father's Name (First, Middle, La John VanScoy	ist)				1			(First, Middle, M	Aaiden Suman	16)		
ary	should ind Men in marke	To	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (5	Street an			I Route Number	City or Town,	State, Zip	Code)	
	and 2 sealth ar n 27 is		Linda Kolman-	daughter					Roa		nit 20				1093
Baltimore,	Pages 1 and 2 should nent of Health and Mer ant; if item 27 is marke ury or other traumatic		20a. Method of Disposition  ¶☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Gar	Place of Dispo cemetery, crer dens O Ceme	f Fait	of ar place) h	1	0–18		20c. Location - Rossvil	•		£
Balt	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Li	ME Fredse		8	Name and 800 Ha Parkvi	rioi	ra ko	bad -	ns fune	RAL CHA	PEL A	AND CREE	MATION VICES
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart lailure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	1 HC	h. Do not ent	er the mode	of dying,	Such as o	cardiac o	r respiratory arre	est,		Approximate Interval Bety Onset and D	ween
8760, 🤡	cate be executed physicien and the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.											
.O. Box 6	the death certifi y the ettending I ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic preg						te of delive		'ear
rds, P	law requires that es been signed b 2 should be deta	ρ	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	ndertying cau	se given	in Part I.		23e. Did tob	acco use cont s 2 1 No		ne cause of de ably 4 🔲 U	
Vital Records,	0 - 0	Completed									24a. Was ar autops perform 1 Yes 2	ned?/	Were autopprior to condeath?	psy findings a npletion of ca	ivailable ause ol
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hardet.				1		of Death	(Check only on				
5	this aldii	7	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Inpati		ER/Outpatien		Other	4 🗀 14 UI		ne 5 Reside 28d. Describe ho			()	
ion	Attending r death.	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Di	ay Year)	Injury	М	. Injury a Work? 1 □ Ye	s 2 🗆 N			ii iijaiy ooouii	00		
Division of	al or Attend s efter death il Director: /	Certification:	3 Suicide 6 Could no 4 Homicide determin	288. Place of Ir	njury - At ho	ome, farm, str y)	reet, factory, o	ffice		2	281. Location (St. City or Town		er or Rura	i Route Numb	⊅er,
	To the Hospital or Attending I within 24 hours effer death.  To the Funerel Director: After completely filled in by the funer	edicai (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner s	of examina	wledge, death	n occurred at vestigation, in	the time my opii	, date and nion, deat	d place, a	and due to the ca ad at the time, da	use(s) and ma ite and place,	inner as st and due to	ated. the cause(s)	1
)	To the To the comp	M	29b. Signature and title of certifier	i Clau	Par	J MI	)	icense i	140	6		OCC	16th	200	6
			30. Name and address of person w	ho completed cause of	death (Item	69 Type.	Priot) CHA	RL	ES	ST	REET	212C	107	MORE	į
	Sta Registr		31. Date filed (Month, Day, Year)	7 2006 32. Régist	trar's Signa	iture	poste	,							

Dora, Kolman

			For State Registrar	State o	f Marylar		artment of I		ind Mer		gienez () (	16	32798
			Decedent's Name (First, Middle)	, Last)					2.	Date of Dea	ath		3. Time of Death
	Physicia		DORIS				K	J088		Month -	14- C	Year 6	4:30PM
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town,				4c. County		1/
	LAGIIIII	ÇI	Franklin Squ	rare Hos	0.401		Kosa	eda/e	0		Bal	tir	NOVE
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year		24 Hrs. 8. Min.	Date of Birt	h Vear	9. Birth	place (State or Foreign
	Director		215-40-5591	1□M 2∏F	64	Yrs.	Months Days	Hours	Jυ	Month, Da	3 1942		ryland
g	>		Usual Residence of Decedent  10a. State 10b. County		100 C	ity. Town or Lo	anation .						10d. Inside City Limits
aryla	Short I	7		•			ZCALION						1 Yes 2 No
	188-1	ecto	MD Balt  10e. Street and Number	imore	E	ssex	104 7:- Codo				10g. Citizen of W	hat Cau	
ži.	23a or 28a-f show unt be notified at	Ö	1029 Arnclif	fe Road			10f. Zip Code 212	21			U.S.A		nuy!
hadth	18 23 must	Funeral Director	11. Marital Status		edent Ever in U	J.S. 13	Was Decedent of		nin? (Specify	Yes or No			can Indian,
(a)	ritems	핖	1 Never Married 2 Marr	Armed Fo	rces?		If Yes, specify Cul	oan, Mexican	, Puèrto Rica	an, etc.)	Black	c, White,	
036 urs a	al', or Exami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	vers:		1 ☐ Yes 2 🔀 No	Specify:			Specify:	Whi	ite
1215-0036 with the Maryland	"natural", rdical Exe	Completed	15. Deceden (Specify only highes			16a. Dece	dent's Usual Occu	pation during most	of working		16b. Kind of Bu	siness/Ir	ndustry
12 Z	than the Max	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	lite.	DO NOT use retire	9d)	3				
ONB	Hygier ther th		11	1 1		Tow 1	Motor O				Contine Maiden Sumam		al Co
	d d	Be	17. Father's Name (First, Middle, Henry Zimmer)								Carder	')	
aryla	h and Mer 7 is marke traumatic	ဥ	19a. Informant's Name/Relations			10b Maili	ng Address (Stree					State Zi	n Coda)
Ma	th and		Charles Knop		and		Arncl:						
	Heell tem 2 other		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		Date	-	20c. Location -		
mor Pages	ont of t: If it		1 Burial 2 Cremation 4 Donation 5 Other (S		State Ho	cemetery, cre. Olly F	matory`or other pla 1i11 Cei	m . 1	0/18/	06	White N	lars	sh, MD
			21, Signature of Funeral Service		1	2:	2. Name and Addr	ess of Facility	V 200				alto. MD
Balt	Depa tmpo eny ti		Valletile	0 106	10	Co	nnelly	Fune	ral H	Mace Iome	of Esse	X Be	21221
			23a. Part 1, Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dea	ith. Do not en	ter the mode of dy	ing, such as	cardiac or re	spiratory a	rest,		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition	- Net	astat	tic 1	Adeno	carci	nom	9			2 months
	Medical xaminer		resulting in death)	Due to	(or as a conse	quence of):				•			
		7	Sequentially list conditions,	b. Bole	(or as a conse		actions						Iday
/ 9	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>(</b>	(01 83 8 0011301	querice or).							
D, executed	sicien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):						-	
8760,	sicier a buri	dicai E											
68 ifficat	g physi as the t	edic											
Box eath certi	endin use	Z/W	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		⊒Ectopic pregnan	74			23d. Date		
Geal Ge	e atte	Physician/Me	in the past 12 months? 1 □ Yes 2 No		nant at time of		Other (specify)	~y			Mor	th	Day Year
P.O.	by th	hys	9 Unknown										
dS, I	signed 1 be de	ρ	Part II. Dther significant condition	ons contributing to d	eath but not re	sulting in the u	inderlying cause g	iven in Part I.		23e. Did t	/		the cause of death? bably 4 Unknown
O. O.	peen	etec								24a. Was	24h V	loss out	annu findinga quallahta
Be a	99 2	Completed								autor	med?	nor to co	opsy findings available ompletion of cause of
<u> </u>	ificete or, pa	ပိ	25. Was case referred termedica					26 Diese	of Dooth (C	1 Yes		∐ Yes	2 No
ic Ki	s cert irect	00	examiner?	Hospital:	patient 2	☐ ER/Outpatie	ot 30 004 0	thor	of Death (C		dence 6 □Othe	r /Spec	6.1
o of	eral c	n: To	27. Mannes of Death	28a. Date	of Injury ith, Day Year)	28b. Time o					now injury occurre		•97
igin	r: Aft	atio	1 ☑Naturat 5 ☐ Pendir 2 ☐ Accident investi	9	in, Day rear)	Injury		Yes 2 ☐	No				
Division of Vital Records,	er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place build	of Injury - At I	home, farm, st	reet, factory, office	)	28f.	Location (:	Street and Number	r or Rur	al Route Number,
	rs aft e DI ed in	Cer											
Hosp	within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1 ♥ Certifyir (Check only 2 ☐ Medical one)	ng Physician: To the Examiner: On the band man	e best of my kn asis of examin iner stated.	nowledge, deal nation and/or in	th occurred at the overtigation, in my	time, date and opinion, deat	d place, and th occurred	due to the at the time,	cause(s) and ma date and place, a	ner as s	stated. to the cause(s)
0 1	within To th compl	₩	29b. Signature and title of certifie	r			29c. Licer	ise number			29d. Date signed	(Month,	Day, Year)
	/		10	PHYS	エレエト	LN.	Dog	586	175		october	. (6	,2006
	5		30. Name and address of person				, Print)						
	1		. 1. 5	MINUS 77	ना। प	HILAD	ATHOUS !	2040	5037	E 208	BACTI	ORF	MO 21237
	Sta Registr		31. Date filed (Month, Day, Year)	7 2006	Applistrar's Sign	nature	Somethe)						-
1/2			5.75.4 E 12.	B PAAAA	Service Control of the Control	COPPET SE	1						

06-07643 Vilma King Please Type or Print in Black Indelible Ink

riima King	1- For State Registrar		e of Death	Reg No. 20	106. 3279
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)	V'		Date of Death     Month Day Year     October 10, 2006	3. Time of Death 1454 hrs
· ·	4a. Facility Name (if not institution, give s	treet and number)	4b. City, Town, or Location of Death		Death
Funeral	Good Samaritan Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Baltimore  ay) If Under 1 Year   If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or
Director	213-70-1339 10M	2VF 48	Yrs. Months Days Hours Min	Nov 16 1957	Foreign Country) MD
any	Usual Residence of Decedent  10a. State  10b. County N / K	10c. City, Town or	Location		10d. Inside City Limits
rland -f show once.	MD		Baltimore 1101, Zio Gode	10g. Citizen of Wha	1 Ves 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number	Chant	a1918	Tog. Citizen of vviia	ac (\sqrt{s}
sr death with to	11. Marital Status	22. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		American Indian, Black, etc.
ter deat ", or ite er must	3   Widowed 4   Divorced in	1 Yes 2 No Yes, Give Year	1 Yes 2 No specify:	Specify:	Black
nours aft natural" 'Asmine		dur	cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use ret		
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Cleaner	OFFI	ce Cleaner
	17. Father's Name (First, Middle, Last)		18.Mother's Name	e (First, Middle, Maiden Surname)	CC Garrin
2121 ould be fil d Mental h s marked tic event,	19a Informant's Name/Relationship (Typ	),  , Print )	Mailing Address (Street and Number or	Stanle / Rural Route Number, City or lown	, State, Zip Code)
MD nd 2 sho alth and nn 27 is aumati	Denise McNai		as E 30 th St	Date 20c Location -	D 21218 City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite nijury or other tr	20a. Method of Disposition  1	Removal from State crematory	or other place)	Date 200. Eocalida	
Baltimo permit. Pag Department Important: injury or ot	4 Donation 5 Other Specify: 21. Signature of Funeral Service License	e Livini	22 Name and Address of acility	etts Funeral F	lome
	Latricia De	ations that caused the death. Do not e	11a9 N. Caroline S	or respiratory arrest shock or hea	<del>/ 0:10:10</del>
Physician /Medical	failure. List only one cause on each			,,,	Between Onset and Death
Examiner		ue to (or as a consequence of):			
ner	Sequentially list conditions, —	ue to (or as a consequence of):			
ted Insit	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):			
60, ate be executed bysician and busial - transi	dd	AMENDED 27 20 EMI	2 064 2/15/07 IIII		
760, cate be execut physician and the burial - trau	IF FEMALE:	#23a,27,28a-I, penvil		23d. Date of c	
Box 687 te death certific the attending ped for use as the	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn  Other (Specify)	ancy Month	Day Year
b. Box 687 the death certific the attending ched for use as t Physician/	1 Yes 2 No 9 V Unknown  Part II. Other significant conditions	9 Unknown  Ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the staffer death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P					Probably 4 V Unknown
Records, The law requires fricate has been signage 2 should b				autopsy pr	Vere autopsy findings available rior to completion of cause of eath?
Rec The la fficate h			26.Place of Death (Check	1 Yes 2 No 1	Yes 2 No
Vital ysician this cert director	1 ✓ Yes 2 No	spital: 1 Inpatient 2 🗸 ER/Outp	Othor	ng Home 5 Residence 6	Other:
n of ding Ph		(Month, Day,Year)	28c. Injury at Work?	28d. Describe how injury occurre	
Division o spital or Attending nours after death neral Director: After filled in by the func Certification:	2 X Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At home farm	2.00piii	subject consumed se 28f. Location (Street and Number or Town, State) 3039	
Div Hospital of 24 hours af Funeral D stely filled i	4 Homicide determined	(Specify) Other—Adult I		Baltimore, MD	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier (Check only one)  2  Medical Examiner:		occurred at the time, date and place, an estigation, in my opinion, death occurred		
Z Z Z S Z	29b. Signature and title of certifier	D 1 0 1	29c. License number		d (Month, Day, Year)
Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	30 Name and address of person who co	moleted cause of death (Item 23c)	O.C.M.E.	October 11	, 2006
120	Zabiullah Ali, M.D. Assist	ant Medical Examiner 111	Penn Street, Baltimore, MD 2	1201	
State Registra	007 5 17 211115	32 Registrar's Signature	Essell 1		

			For State Registrar	State of Maryland		tment of F			ene 2006	32800
	The spinger		Decedent's Name (First, Middle, La.	st)				2. Date of Death	)	3. Time of Death
- 4	Physicia		Elaine J.	Kruse				Month 1 O	Day Yea	1 3 1 3 M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Deatl		4c. County of De	
	LAUITILI		University of Mary	land Medical	Center	Raltin	ove			_
 	Funeral	S	5. Social Security Number 6. S	ex 7. Age (In yrs. Is	adi dininday/	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. B	inhplace (State or Foreign Country)
	Director		219-18-1039	□ M 2 K F 82	Yrs.		Fe	bruary I	),1924	Maryland
	pur *	-	Usual Residence of Decedent  10a. State 10b. County	10c City	/. Town or Loca	tion				10d. Inside City Limits
	sho	ÖN								1 Yes 2 No
	he N	ecto	10e. Street and Number	ra be	el Air	10( 7:- Codo	-	10	g. Citizen of What (	
	with t	늅	52 East Broadway			10f. Zip Code <b>2101</b>	4			es of America
	s 23	eral	11. Marital Status	12. Was Decedent Ever in U.S	S 12 W		•	i		nerican Indian,
36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amd Mental Hygiene ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exameter must be coulding a	by Fun	In Marital Status    Never Married   Divorce	Armed Forces?  1  Yes, GiveA Year or Dates:	1	Yes X No	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, Wi	nite, etc.
21215-0036	tura tura	pe	15. Decedent's E		16a. Decede	nt's Usual Occup	ation	1	6b. Kind of Busines	
15	in 72 n "ne	plet	(Specify only highest gra	de completed)	(Give kii	nd of work done  NOT use retired	during most of wor	king		
77	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Regis	ster Nur	se	F	lealth Car	re
ਹ	filled Hygi other	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle, M	laiden Sumame)	
Maryland	lid be fental rked c	To B	Marshall M. War	ner			Rose S	. Kuhn		
ary	2 shoul and Me is mari	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing	Address (Street	and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
	and 2 lealth a m 27 is		Joseph M. Krus	e (Son)	1707	Pleasant	ville Ro	ad. Fores	t Hill, N	<b>Ф. 21050</b>
ē,			20a. Method of Disposition	20b. PI	lace of Disposit				Oc. Location - City	
9	age ent o nt: If y or		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State +		ark Ceme		/19/06 W	loodlawn,	Maryland
Baltimore,	permit. Pages of Popartment of Minportant: If Ite any injury or of popartment.	1	21. Signature of Funeral Service Licer	,,			Ξ,			Directors,Ir
ñ	Depa Impo any i		1 Charles 1	Kollmer Moo3	W 87	28 Tiber	LU Load vt	Pandalla	s runeral	ryland 21133
	Section 1		23a. Pay 1 Enter the disease or com	plications that caused the death						Approximate
			street, or heart failure. List only Immediate Cause (Final		- ^					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. My Cardial  Due to (or as a consequ	Infar	C404				
	Examiner			,	•		<b>-</b>			
п		<u>-</u>	Sequentially list conditions,	b. Cerebrovas	uence of):	acciaer	11			
	ted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		- Hation					
	xecu and	хаг	that initiated events resulting in death) Last	c. Atrial Fibr	11					
8760,	cate be executed physician and the burial-transit		· ·							
387	death certificate be executed e attending physician and nd for use as the burial-transif	Physician/Medical		d						
9 X	death certifica attending ph d for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				23d. Date of d	lolivon
Вох	atten atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3⊟E	ctopic pregnancy Other (specify)	1		Month	Day Year
	the de	yslc	1 ☐ Yes 2 ဩ No 9 ☐ Unknown	9☐ Unknown	adii 5 (	other (specify)				
P.0	that the died by the detached		Part II. Other significant conditions of	contributing to death but not resu	ulting in the und	erlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
of Vital Records,	Se us	l by	•	•	•	., , ,		1 □ Ye	s 2 No 3	Probably 4 Munknown
0	w requir been si should	Completed								
ec	G 5 C1	du						24a. Was an autopsy	prior to	autopsy findings available o completion of cause of
<u></u>		ő						perform 1 Yes 2		es 2 No
/ita	sician: Certifice	Be	25. Was case referred to medical examiner?	11 2-1		100		th (Check only one	)	
£	S S D	ို	1 ☐ Yes 2 ☑ No		ER/Outpatient		4 🗆 IVui Sirig F		nce 6 Other (Sp	pecify)
L	on the land	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	w injury occurred	
sio	Attending ir death. ector: After by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □No			
Division	or At after d Direct in by	E	4 Homicide determined		ome, farm, stree /)	t, factory, office		28f. Location (Str City or Town		Rural Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A Completely filled in by the to									
	To the Hospital within 24 hours (To the Funeral Completely filled	edical	(Check only 2 Medical Example 12 Medical Example 2 Medical Example	ysician: To the best of my knowniner: On the basis of examinat						
	the the	Med	one)	and manner stated.		29c. Licens	e number	-10	d. Date signed (Mo	ofth Day Year
	5 1 E S		29b. Signature and title of certifier	4.0			16435H1			
,	1		1 yours	^D		4041	6-137111	111/	10/15/00	•
	5		30. Name and address of person who							
				South Greene St		more, 1	UD		<u></u>	
	Sta	1.7	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	-				
	Registi	ar	OCT 1 7 2	UUD Market	He Ken	SAME IS				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mary		ertificate of			giene Reg. No 200	6 32801
			1. Decedent's Name (First, Middle, La.	st)		·····		2. Date of Dea Month	ath	3. Time of Death
	Physici /Medio		William		Kor	dis		October	$1^{Day}$ , 200	06 12:03 P M
,	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of	
			3105 Cornwall Roa  5. Social Security Number 6. S		yrs. last birthda	Dunda.	LK If Under 24 Hrs.	8. Date of Birt	Balti	P. Birthplace (State or Foreign
П	Funeral Director			MM 2□F	81 Yrs.	Months Days	Hours Min.	January	14, 1925	Country) PA.
			Usual Residence of Decedent							
	anylan ehow	_	10a. State 10b. County		City, Town or	ocation dalk				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	Directo	Maryland Baltimo	re	Duit	10f. Zip Code			10g. Citizen of Wh	
	be filed within 72 hours after death with the Marylar ital Hyglana. Id other than "natural", or Items 23a or 28a-f show ovent, the Madical Examiliser must be notified at	ΙDir	3105 Cornwall Roa	d		212	22		USA	iat Courty:
	death ms 23	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13	. Was Decedent of h	Hispanic Origin? (Sp	ecify Yes or No-		- American Indian,
9	or Its		1 Never Married 2 Married	Armed Forces? 1 1 Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2X No	an, Mexican, Puerto  Specify:	Hican, etc.)		White, etc. White
2	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:	1 10 0					
က်	n 72 in 72 in at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Bus	iness/Industry
212	iane.	omo	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	М	illwright	-7		Bethlehe	em Steel
힏	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nam			)
<u>X</u>		Tof	Ignatz Kordis				Margare			
Maryland 21215-0036	d 2 should th and Mer 7 ie marke treumetic		19a. Informant's Name/Relationship (	_		ling Address (Street  1 Golf Cl				
	1 and Health em 27 ther ti		Bill Kordis  20a. Method of Disposition	Son	0b. Place of Dis	position (Name of	0-4-			ity or Town, State
ğ	Pages nent of int: If It iry or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cr	ematory`or other pla Forest V				Mills, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If Item 27 if eny Injury or other tre		21. Signature of Funeral Service Licer		Λ	22. Name and Addre				
ä	ed in a	1	Chickory	Connel	ly	7110 Soll	ers Point	Road, I	Dundalk, N	1D. 21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
. 1	Pnysician		Immediate Cause (Final disease or condition	. (0	40					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	nsequence of):					
		Į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	exec en an	Еха	resulting in death) Last	Due to (or as a cor	nsequence of):					
8760,	cate be executed bhysicien and tha burial-transit	dicai		d						
9	ertific ding p	Mec	IF FEMALE:	220 If you sutcome of pr						
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 4 Pregnant at time	Fetal death 3	☐ Ectopic pregnanc	у		23d. Date Mont	
o.	at the de by the a	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	or death 5		· · · · · · · · · · · · · · · · · · ·			
<u>.</u>	The law requires that the death certific ste has been signed by the attending p sage 2 should be deteched for use as	by Pl	Part II. Other significant conditions of	contributing to death but no	t resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ğ	w require been sig should b	edt	<u></u>	70				1 🖫	es 2□No 3	Probably 4 Unknown
Records,	has be ge 2 sho	Completed						24a. Was a	an 24b. We	ere autopsy findings available or to completion of cause of
<u>~</u>		Con						perfor 1 ☐ Yes	med≫   de	ath? ☐Yes 2☐ No
<u> </u>	nysicien: Th nis certificete I director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ont all DOA Ott	26. Place of Deat			
ō	~ = ~	. To	1 Yes 2 Na 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpati	of 28c. Injui	ry at		lence 6 Other	
0	nding F ath. r: After e funera	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury	Wo	rk? ]Yes 2 □ No			
Division of Vital	al or Attendi after death. I Director: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b		At home, farm, s	street, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Route Number,
ā	itato Irsaft rel DI Iled in					197 <u>0</u> :	79			
	Hosp 24 hou Fune rtely fi	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of exa and manner stated.	/ knowledge, dea mination and/or	ath occurred at the ti- investigation, in my o	me, date and place, opinion, death occur	and due to the or red at the time, or	cause(s) and mani date and place, an	ner as stated. Id due to the cause(s)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
)	人。		> 8~X	2		Dr	17299		10/10	100
/	1		30. Name and address of per who	comple at cause of death	(Item 23a) (Type	e, Print)		10	11	2 /
	7		B 2 CW MI	Jr. (	1940	Cant	ero Ch	e Bo	Mimor	YELL OM &
	Sta Registi		31. Date filed (Month, Day, Year)	32. Aegistrar's S	signature	Carel 9				
				12 12 12 12 12 12 12 12 12 12 12 12 12 1	100	*				

DHMH 17 Rev 1/2001

Registrar

2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 0.0 C

			1 - State Registrar			partment of learning of the contract of the co		Reg	en <b>2</b> 0 0 6 a. No.	32803
ı	Physici /Medic		Decedent's Name (First, Middle, I  IDA	Last)	KO(	GAN		2. Date of Death	R <sup>™</sup> 13, 2006	3. Time of Death 7:32 A M
	Examin		4a. Facility Name (If not institution, g		316		or Location of Death	A		HOWARD
	Funeral Director		117-32-0357	Sex 7. Age	92 Yrs.	Months Days		8. Date of Birth 10/11/1	9. Birth	place (State or Foreign ntry) NY
	nyland ahow	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	he Ma Sa-f.	Director	MD HOWA	(RD	COI	_UMBIA				1 ☐ Yes 2 ☑ No
	ath with t	rai Dir	10e. Street and Number 5400 VANTAGE PO	OINT ROAD #8		10f. Zip Code	21044		g. Citizen of What Cou	USA
920	filed within 72 hours after death with the Maryland I Hyglene other than "natural", or Itema 23a or 28a-1 ahow ent, the Medical Examinar must be codified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 1 No		pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify:	
<u>2</u>	72 h	etec	15. Decedent's (Specify only highest of	Education grade completed)	16a. De (G	cedent's Usual Occu ive kind of work done b. DO NOT use retire	pation during most of wor	rking 16	6b. Kind of Business/In	dustry
212	filed within Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5		CRETARY	əd)		HOSPITAL	
Maryland 21215-0036	Q 4 4 5	To Be	17. Father's Name (First, Middle, La I SAAC	st)	RO	THENBERG	18. Mother's Nan REBECC	ne (First, Middle, Ma A		CKERBERG
Mary	nd 2 should Ith and Men 27 is marks traumatic	18	19a. Informant's Name/Relationship ROBERT KOGAN /			ailing Address (Stree			CITY, MD 2	
Baitimore,	Pages 1 and nent of Health int: if item 27 iry or other to		20a. Method of Disposition 1 🂢 Burial 2 □ Cremation 3		20b. Place of Dis	sposition (Name of rematory or other pla	ace)	Date 20	oc. Location - City or To	own, State
	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of uneral Service Lice	cify)	CEDAR PA	RK CEMETE 22. Name and Addr		16/2006	PARAMUS, ON & BROS.	NEW JERSEY
ñ	Deg mi yug		> Scatt N	1 with		8900 REIS	STERSTOWN	ROAD - P	IKESVILLE,	MD 21208
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	implications that caused by one cause on each lin MYCLO		STIL SYN		or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	logenous	1 /	mia		3 muly
	ried insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):			, , , , , ,		3
60,	death certificate be executed e attending physicien and id for use as the burial-transit	ai Examin	that initiated events resulting in death) Last	C Due to (or as a	a consequence of):					
09/89	rtificate ng phys s as the	Medicai	IF FEMALE:	0		-				
O. Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey		23d. Date of delive Month	ery Day Year
JS, P.	es tha	٥	Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying cause g	ven in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Vital Hecords,	law requir es been si 2 should	Completed						24a. Was an autopsy	24b. Were auld	psy findings available mpletion of cause of
r a				-				performe 1 Yes 2	d? death?	
5	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpat	ient 3 DOA Ct	hor	ath (Check only one)	ce 6 ☐Other (Specif	
	nding Phy th. :: After this e funeral d	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day		of 28c. Inju	· · · · · · · · · · · · · · · · · · ·	28d. Describe how		у)
DIVISION	al or Attending s after death. il Director: After od in by the fune	Certification;	3 Suicide 6 Could not determine		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number.
	To the Hospital or Attuwithin 24 hours after de To the Funeral Direct completely filled in by the	Medical (	29a. Certifier 1 Check only one) 1 Medical Ex	Physicien: To the best of aminer: On the basis of and manner sta	examination and/or	eath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the cau irred at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	111		_	se number		I. Date signed (Month,	
)	1		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type	D3,	8509	a	tches 13 7	2004
	V		NICHULAS / Scu. 31. Date filed (Month, Day, Year)	Freletus 11	1065 Li44	le PATEX	ent Pky	Column	SIG MD.	21044
	Sta Registr		O. Date med (World, Day, Tear)	2006 32. Hegistra	r's Signature	1000 C				•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 860 10-17-06 vt State of Maryland / Bepartment of Health and Mental Hygiene Reg. No. 0 32804 06 Certificate of Death 1. Decedent's Name (First, Middle, Last) Maria C. Lovett 2. Date of Death Physician Year LOVET 0525 Uctober 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballmore City N/A Honduis I he Johns If Under 24 Hr 5. Social Security Number 6. Sex ge (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 14, 1919 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 200 216-82-9517 86 Yrs. Dec. Director Italy Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at txores 2 □ No N/A Baltimore Directo Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 610 W. 34th Street 21211 USA 238 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Designer Clothing 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Giuseppe Grupposo Amelia Galli ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Heelth ar Important: if item 27 is any injury or other treu Husband 610 W. 34th Street Charles R. Lovett Baltimore, Maryland 21211 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Druid Ridge Cemetery 10/7/2006 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura f Funeral Service in see Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road Baltimore, Maryland 21211 Juli 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 24 Hours HEMATOMA **Physician** /Medical Due to (or as a consequence of) Examiner De sorrous si contra sum es Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical EXPERIMENT REPROPER BY IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 27 No certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
11XYes 2 □ No Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA this : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending investigation Oct. 02, 2006 0800 AM death. 1 🗌 Yes Subjec Director: , 281. Location (Street and Number or Rural Rouge Number )
City or Town, State)
610 W. 34 ST. BALTIMOLE N 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours efter or To the Funerel Direct completely filled in by 4 Homicide HOME 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RE5-000 OCTOBER 6, 2006 oodweg/ M.D.

Registrar

DHMH 17 Rev 1/2001

State

600 N, WOLFE ST. BALTIMINE, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRAEME WOODWINTH 600 N, WOLF

32. Registrar's Signature

			1 - For Amend Registrar	Ite	State of <b>23a</b>	Marylai per dr	. <b>6860</b>	ortifica	7/06dhb ite of Dec	Ith and M ath			2006	32805
	Physici		1. Decedent's Name (First, Midd Geraldin		Lee						2. Date of Dea Month SEPTEMI	Day	30 2006	3. Time of Death 8:30 PM
<i>j</i>	/Medic Examin		4a. Facility Name (If not institution MCTCY MCALCA  5. Social Security Number	6. Sex	nter		. last birthday) Yrs.	Ba			8. Date of Birth (Month, Day	Year)	Co	hplace (State or Foreign
	Director		212-40-1960  Usual Residence of Decedent  10a. State 10b. Count				ity, Town or Lo	cation			Augl6,	194		MD  10d. Inside City Limits
	Maryla If show	tor	MD 100. Count		N/A	100.0			timore					1 Yes 2 □ No
	or 289	Funeral Director	10e. Street and Number					10f.	Zip Code	_			zen of What Co	ountry?
	ns 23a	erai	1301 N. Cen		12. Was Dece			Was De	2120	ic Origin? (Spe	ecify Yes or No-		J.S.A. 14. Race - Ame	orican Indian,
920	ours after o ral', or Iten Exercitor	5	1 Never Married 2 X Ma 3 Widowed 4 Divorce	1	Armed For 1 Yes If Yes, Giv Year or Da	21 No		If Yes, s	pecify Cuban, Me	exican, Puèrto	Rican, etc.)		Black, White	_
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any fujury or other treumatic event, the Medical Exact at must be notified at once.	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)			-4or 5+)	(Give	kind of DO NOT	sual Occupation work done during ruse retired)	g most of work	ing		nd of Business/	·
2 pد	e filed al Hygie other vent, ti	Be Co	12th 17. Father's Name (First, Middle	Last)			) Sea	IIIS C		Mother's Name	(First, Middle,			
Maryland	Menta	To E	Oliver Watk		8:0		401 14 17		(2)	Berni		0	Loney	7 0 11
Ma	nd 2 shallth and 27 ls n		19a. Informant's Name/Relation Karen Loney/					•	ess (Street and N W. Hope			•		
nore,	ages 1 au int of Hea t: If item y or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (	3 □R	_	State	Place of Dispo cemetery, crea	osition (fi matory o	vame of er other place)		Date	20c. Lo	cation - City or	Town, State
Baltimore,	permit. P Departme Importan any Injur		21. Signature of Funeral Service		N	I WC		2. Name	and Address of VIN B. 2 E. Pi				TIMORI L HOMI	
			23a. Part1. Enter the disease, c shock, or heart failure. Lis	r compli	ications that can be cause in ea	aused the dea	ath. Do not en	er the m	ode of dying, su	ch as cardiac	or respiratory ari	est,	1110 214	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	carc	laopu	mone		arres					hours
	Examiner			1	USP	or as a conse	quence of):	\spi	ration I	Pneumon	ia			hours
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (	or as a conse	quence of):							
8760,	ficate be executed physicien and is the burial-transit	dical Examin	that initiated events resulting in death) Last		Due to (	or as a conse	quence of):							
Ψ	death certifica attending ph d for use es th		IF FEMALE:	2	3c. If yes, out	come of pregr	nancy						23d. Date of del	bion.
P.O. Box	0 4 2	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		1□Live bi	inth 2□Fel ant at time of	al death 3		pregnancy (specify)				Month	Day Year
	law requires that the es been signed by th 2 should be detache	Ď	Part II. Other significent condit		ntributing to de	ath but not re	sulting in the u	nderlyin	g cause given in	Part I.				the cause of death?
of Vital Records,	The ate h page	Completed									24a. Was a autop: perfor 1 Yes	sy	prior to death?	utopsy findings available completion of cause of
Vita Vita	ysician: Th is certificate director, pag	o Be	25. Was case referred to medic examiner?  1 → Yes 2 → No	-	lospital:	anationt 2	☐ ER/Outpatie	* 2 n	Othor		Check only or		Cohen (Con	a/4.1
	Attending Physician: ir death. ector; After this certific by the funeral director.	<del>-</del>	27. Manner of Death 1 Manual 5 ☐ Pend	ng igation	28a. Date o		28b. Time of Injury		28c. Injury at Work?		me 5 Resid 28d. Describe h			ony)
Division	- B - C	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	not be nined		of Injury - At I	home, farm, st ify)	reet, fact	ory, office		28f. Location (S City or Tow			ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. Yo the Funeral Director: After th pompletely filled in by the funeral	edicai (	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Phys I Exemi	sician: To the ner: On the ba and mann	isis of examin	nowledge, deat nation and/or in	h occurr vestigati	ed at the time, da ion, in my opinion	ate and place, n, death occurr	and due to the d ed at the time, o	ause(s) late and	and manner as place, and due	s stated. I to the cause(s)
	withii To tr	Ž	29b. Signature and title of certific	-				1	29c. License nun	S 25 W			e signed (Monti	**
	8		20 Name and address of person				m 23a\ /T	Drine)	D641	466	S	epre	mber 3	30,2006
_	<i>U</i>		Anita Tsen, 301	St.				,	10 2120	اد				
	Sta Registi		31. Date filed (Month, Day, Year	006	32. R	egistrar's Sigr		Marie at						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32806 State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6:20 PM Dolores C. McKenny 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Robert State of Birth (Month Day), Year Days Hours Min. 06/25/1916 4c. County of Death 4b. City, Town, or Location of Death Franklin Squart Ba HOSPIta HIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2QF Yrs. 214-74-9925 90 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes ¾QXNo BAltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 300 N. Marlyn Avenue 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3€ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Matthew Kalb Frances Faulstich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 539 Stratford Rd Fallston, MD 21047 Thomas G. McKenny Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery 10/19/06 Baltimore, 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave Balto MD Connelly Funeral Home of Essex 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . large left middle CEREBRAL ORLERY infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTK 2 No 3 Probably 4 Vunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical Examiner led by the attending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Iteme 23a or 28a-f ehow the Modical Exercities must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Importent: if item 27 is marked other th eny injury or other treumatic event, the 2002.

21215-0036

timore, Maryland

Kenny

Direct

Funerai

Ŕ

Completed

Be

Examine

Physician/Medical

ģ

Be Completed

2

Certification:

Medical

within 24 hours elter death. To the Funeral Director: Alter this centificate has been signed completely filled in by the funeral director, page 2 should be del To the Hospitel within 24 hours ele To the Funeral D

			1 Yes 2 No 1 Yes 2 No										
25. Was case referred to medical		26. Place of Death (Check only one)											
examiner? 1 Yes 2 No	Hospital: 1 ₭ Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Home	ig Home 5 ☐ Residence 6 ☐ Other (Specify)										
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury N	Work?	. Describe how injury occurred										
3 Suicide 6 Could not be determined		actory, office 28f	Location (Street and Number or Rural Route Number, City or Town, State)										
	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investigand manner stated.		due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)										
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)										
Harling	MD	RESOUDO	10/15/06										
20 Name and address of parent who	and a later of any of death (tem 22a) (Type Driet)												

Sq. dr. Balymore, HD 21237

State Registrar

10

Franklin

9000

2006 32. Registrar's Signature

Park

Hang

31. Date filed (Month,

			State of Maryla	nd / Denartm	ent of Health and	Mental Hyd	riene.	
		1 - State Registrar	Olato of Maryla		ate of Death		2006	32807
Dhuni		Decedent's Name (First, Middle, La.	st)			2. Date of Dea		3. Time of Death
Physic /Med		Irene Hel	en Ma		1	October	14 200	
Exam	iner	4a. Facility Name (If not institution, give	~ (	/	ity, Town, or Location of De	ath	4c. County of Dea	. 1
Funera		5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday) ff Ur	der 1 Year   If Under 24 H		Cuvv 9. Bir	thplace (State or Foreign
Directo		212-20-4666	□M 2⊠F	33 Yrs. Mont	hs Days Hours Mi	n. (Month, Day July 15		nnsylvania
and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location		•		10d. Inside City Limits
Maryl f sho	ţ	Maryland Carroll		Sykesville				1 ☐ Yes 2 ☐ No
death with the Maryland me 23a or 28a-f show	Funeral Director	10e. Street and Number		10f.	Zip Code		10g. Citizen of What Co	ountry?
23a c	alD	7003 Carmae Road			21784		USA	
er de	nue	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13. Was De If Yes,	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	14. Race - Ame Black, Whi	
OU36 hours after tural; or ite	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 □ Ye	s ≱☐ No Specify:		Specify:	White
	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's U	Isual Occupation work done during most of w	endkina	16b. Kind of Business	/Industry
Althin Althin	mple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired)	Orking		
d Z 1 Z 1 3- filed within 72 Hygiene. ther then "na! ont, the Medic	S	17. Father's Name (First, Middle, Last)	1	Wait		ame (First, Middle,	Food Maiden Surname)	
Viand  ould be filt  Mental Hy  arked oth  attic even	To Be	John Solomon				nne Mihal	•	
Maryla d 2 should th and Men 7 le marke traumatic		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Addr	ess (Street and Number or I	Rural Route Numbe	r, City or Town, State,	Zip Code)
re, M s 1 and 2 f Health item 27 other tr		Irene Craig	Daughter		mae Road; Syl	<del>_</del>		
Peges 1 Peges 1 Pent of H Int: If ite		20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition ( cemetery, crematory arrison For	or other place)	Date 20/2006	20c. Location - City or	
altimo		4 Donation 5 Other (Specifical Service Communication of Funeral Service Communication of Funeral Service Communication of	7)		and Address of FacilityS t		-	ls, Maryland
Danit. I		* ella	/ Moiz	- Fune	eral Home of Edmondson A	Catonsvil	le Inc	
		23a. Part1. Enter the disease, or com shock, or beart failure. List only	plications that caused the dea		node of dying, such as cardi	ac or respiratory ari	est,	Approximate Interval Between
Physician		fmmediate Cause (Final disease or condition	a Canacst	Ive he	art fartery	lure		Onset and Death
/Medica Examinei		resulting in death)	Due to (of as a conse	quence of):	,	Λ		
	ē	Sequentially list conditions, if any, leading to immediate	b. Or On Or Due to (or as a conse	quence of):	tery	DISTAS	2	
ransit	Examin	Cause. Enter Underlying Cause (Disease or infury that initiated events	с.					
If bu, It is be executed in sicion and he burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
ob/c	dical	•	d					
. BOX 68/ death certificate e ettending phys d for use as the	Physician/Med	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of de	fiverv
	cla	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		c pregnancy (specify)		Month	Day Year
that the de sed by the e	Phys	9 Unknown						
COTAS, F.C. w requires that the sbeen signed by the should be detached.	Þ.	Part II. Other significent conditions of	ontributing to death but not re	sulting in the underlying	ig cause given in Part I.	23e. Did to	bacco use contribute to es 2 1 No 3 □ Pi	o the cause of death?  robably 4 Unknown
- A 70	Completed					24a. Was a		itopsy findings available
6 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	a mo					autop: perfor	sy prior to death?	compfetion of cause of
VICION: The certificete	Be C	25. Was case referred to medical examiner?			26. Place of D	1 ☐ Yes eath (Check only or		20 10
OT V Physic rthis ce ral dire	10	1 ☐ Yes 2 ◯ No		ER/Outpatient 3			ence 6 Other (Spe	cify)
ding F	tlon	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c, Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
INISION  or Attending after death. Director: Afte	flca	3 ☐ Suicide 6 ☐ Could not be	e 28e. Place of fniury - At h	nome, farm, street, fac			treet and Number or R	ural Route Number,
rs afte	Certification;	4 Homicide	building, etc. (Spec	ity)		City or Tow	n, State)	
DIVISION OF VITA  To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exen	ysician: To the best of my kn niner: On the basis of examin	owledge, death occur ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner as late and place, and due	s stated. to the cause(s)
o the lithin 2 o the omplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		9d. Date signed (Mont	
F ≩ F 8		*	m	n				
16		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	D28236 Gerpe RQ	) /		· 6
10		Dovian SSTI	martin m	0 700	Geipe RV	89/11	you m	0 2/218
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature Anathr	Ø.			

06-07740 Joseph Magliano

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ Month Day October 15, 2006 Medical Examiner 1210 hrs Joseph Magliano 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 219 Grundy Street **Baltimore** If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months Days Maryland Director 219-88-5715 XX<sub>M 2</sub>F 09/29/1967 39 Usual Residence of Deceden 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits inv N/A 1 X Yes 2 No MD Baltimore or 28a-f show or items 23a or 28a-f sho must be notified at once, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho rights or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 219 S. Grundy Street 21224 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 2X No f Yes, Give Year 1 Yes 2X No specify: 3 Widowed 4 Divorced Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roma Baltimore, MD 21215-0036 Food Specialist 12 Sausage Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Anthony Nicholas Magliano Billie Jacqueline Warnick 19a. Informant's Name/Relationship (Type, Print ) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Magliano/Sister 3J Pantley Ct Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Holy Redeemer Cem. 10/20/06 Baltimore, MD Domation 5 Other Specify 22. Name and Address of Facility 300 Mace Ave Balto MD 21 Signalure of Funeral Servic - License Connelly Funeral Home of Essex 21221 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Mixed Drug intoxication (Oxycodone, Meprobamate) Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical trending physician are use as the burial -X UNPENDED X AMENDED #1.23a,27,28a-f, perME, g862, 12/7/06 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No. 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pending the unknown unknown 2 Accident Investigation unknown in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 219 Gundry Street
Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined (Specify) 4 Homicide other-scene 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal within 2. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Of O.C.M.E. October 16, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State 2006 Registra

	Plea	se Type or	Prin	it in Black	c Ind	elible	lnk.	Ensu	ıre Al	l Copies	Are	Lec	aible.	
For State Registrar				aryland / D	epa		of H	ealth a	and M	lental Hy		20		32809
1. Decedent's Nam Margaret										2. Date of De Month Octobe		ay . <b>5</b> ,	2006	3. Time of Death 10:45 AMM
4a. Facility Name (i 3158 Gra		d Rd. #FC				4b. City, To				ring			nty of Deat	
5. Social Security N 038-24-1		6. Sex 1 ☐ M 2 💢 F	7. Age	68 Y			f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) O2/23/1938 9. Birthplace (State or Foreign Country) RI						hplace (State or Foreign untry)	
Usual Residence of	Decedent													
10a. State	10b. County			10c. City, Town	or Loc	ation								10d. Inside City Limits
MD	Monto	omery		Silver	Sp	ring								1 ☐ Yes 2 🗷 No
10e. Street and Nu	mber					10f. Zip C	ode				10g. C	itizen d	of What Co	ountry?
3158 Gra	cefield	Rd. #FC	206			209	04-				Un	ite	d Sta	ites
11. Marital Status 1  Never Marr 3  Widowed	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2☑No Specify: White					e, etc.								

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Long Term Care Elementary/Secondary (0-12) College (1-4or 5+) Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print) Courtney Deines-Jones/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9516 Colesville Rd. Silver Spring, MD 20901-

Delia Roberge

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Beltsville, Maryland 2006 Rapp Funeral & Cremation Services

Tiple O Chumanu 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Madantota

M00382

Immediate Cause (Final disease or condition resulting in death)

Joseph Melone

**Physician** /Medical Examiner

**Funeral** Director

Be Completed by Funeral Director

filed within 72 hours after death with the Maryland r than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygies Important: If Item 21's marked other transmit any njury or other traumatic event, Item 20068.

**Physician** /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral circlor, page 2 should be detached for use as the burial-transit completely filled in by the funaral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examine

Be Completed by Physician/Medical

2

Certification:

Medical

Sequentially fist or utitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  Carcinoma	arc	Lung	00.00
Due to (or as a consequence of):		0	

933 Gist Ave.

Due to (or as a consequence of)

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

27. Manner of Death 1 Natural

2 Accident 3 🗍 Suicide

4 Homicide

2 in Cartified

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Oct 17 20c. Location - City or Town, State

Silver Spring, Maryland 20910-

Day Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death?

Yes	2 ⊔ No	3 Probably	4 UU
-			
Was an	24h	Ware autoney fil	ndinge a

24a. Was an autopsy performed? 1 Yes 2 No

available prior to completion of cause of death? 2 🗌 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

And Marion in

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of pertition

Cartifying Physiciam: To the bast of my knowledge death conursed at the time, date and plane, and due to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

D24035

10-16-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

3110 GRACEFIELD RO: SILVER SPRING MD 20904 MACHADE MD ELEGENIO 31. Date filed (Month Bay: 32. Aegistrar's Signature

State Registrar

15

DHMH 17 Rev 1/2001

		. For	State of Mary	land / Depa	artment of Health and	Mental Hygie	en@006	32810
		1 - State Registrar		Ce	rtificate of Death	Reg	. No.	
Physicia	an	Decedent's Name (First, Middle, Las				2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	James 4e. Fecility Name (If not institution, give	Edwa	rd	Mitchell  4b. City, Town, or Location of Deat		06 2006 4c. County of Deeth	1:05a.
Examin	er	Northwest Hospi		r	Randallstow		Baltim	ore
Funeral		5. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Dey, Y	(ear) 9. Birth	plece (State or Foreign ntry)
Director		220-38-9783 Usual Residence of Decedent	LIM 2LIF 64	4 Yrs.		12 10	41	MD
land ow		10a. State 10b. County	100	c. City, Town or L	ocation			10d. Inside City Limits
a-f eh	ctor	MD Baltin	nore	Ow	ings Mills			1 ☐ Yes 2 XNo
or 28	Director	10e. Street and Number			10f. Zip Code	109	g. Citizen of What Cou	
sath w	eral	9415 Owings He	ightCircle 12. Was Decedent Ever	#301	21117 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	U.S.A.	
fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes X No Specify:	to Rican, etc.)	Black, White,	etc.
ours a	d by	3 Widowed 4 Divorced	Year or Dates:					lack
natu restriction	lete	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/Ir	dustry
withir lene.	Completed	12th grade	College (1-4or 5+) na		us Operator	Ma	ass Trans	it Adm.
e filed other vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In arked other then "caturel", or Items 23a or 28a-f show imarked other then "caturel", or Items 23a or 28a-f show imarke event, the Maulcal Extrainer matable maillied at	ToE	Edward M. Balla	ard			e Mitche		
12 sho h and r is m		19a. Informant's Name/Relationship (			ng Address (Street and Number or R			
ite, INIGITY INITION AT LATE OF COORD  1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.  Item 27 is marked other then "ceturel", or Items 23a or 28a-f show other traumatic event, the Mardical Extrainer must be maillied at		Alfine Mitchell 20a. Method of Disposition	L-Wife 2	Oh Place of Disp	Owings Height osition (Name of matory or other place)		Dc. Location - City or T	
nit. Peges artment of I ortant: If it injury or o		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific	Removal from State		on Forest Vet_1	0/12/06	Owings M	ills, Md
injustra		21. Signature of Funeral Service Licey			2. Name and Address of Facility Larch F/H West			
Derm Depa Impo		Mala M	arch	14	300 Wabash Ave			21215
		shock, or heart failure. List only	one cause on each line.		iter the mode of dying, such as cardia		Δ	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Seps		with multio	2 gar	- ilnve	
Examiner			A CINTO	Recis	with multion iratory for	Thre		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	ensequence of):	J			
Transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
BOX 08/00, Ce oath certificate be executed attending physicien and for use as the burial-transit	cal Ex	resulting in death) cast	Due to (or as a co	nsequ <i>e</i> nce oi):				
certificate oding physise as the		`	_ d					
OX O	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		□Ectopic pregnancy		23d. Date of deliv	
o death	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time 9☐Unknown		Other (specify)		Month	Day Year
that the deed by the a	Phy	9 Unknown  Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Hecords, P.O. Bo The law requires that the death the has been signed by the atter age 2 should be detached for the	Completed by Physician/Med	Λ	not to	miline	, (C) Cort	1 🗆 Yes	; 2 □ No 3 □ Pro	bably 4 DUaknown
HECOTOS, he law requires t a has been signe tge 2 should be	lete	Mers SI	0 thore	n î	mabilib	24a. Was an		opsy findings available
The lav	mo	te Mean.	Lexeur	101Y V	in farel-	autopsy perform 1 Yes 2	ed? death?	ompletion of cause of 2 No
	Be C	25. Was case referred to medical examiner?				ath (Check only one		
OT V Physic	P	1 ☐ Yes 2 D No	Hospital:	2 ER/Outpatie		Home 5 Residen	ce 6 Other (Spec	(b)
on C ding P Alter funera	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of Injury (Month, Day Ye		of 28c. Injury at Work?  M 1 Yes 2 No	200. Describe nov	v injury occurred	
DIVISION I or Attending after death. I Director: Alte	ifica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, s	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui	ral Route Number,
UN tell or rs afte el Dirr	Certification:	4   Nornicide	building, etc. (S	эрвспу)		0.17 0.1 1011.17		
Division of VIta  To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: Alter this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Pl	hysicien: To the best of m miner: On the basis of exa and manner stated	amination and/or	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
o the ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated		29c. License number	29	d. Date signed (Month	. Dey, Year)
F ≤ F ō		> S. Siddia	IN MD		D30119	(	0/10/06.	
CX		30. Name and address of person who	completed cause of death	h (Item 23a) (Type	, Print)	+ Strong	LAN SII	52
(۲		Showida Sidd  31. Date liled (Month, Day, Year)	32. Registrar's		neve Many C	+ 1/2011	7 . (1) ~ (1)	~ <del>~</del>
St Regist	ate rar	OCT 1 7 2006	Se. Hogistidi's	S Sand				

State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death OCTOBER 12. ŽOO6 **Physician** Msilanga Babu Vedastus 01:10FM /Medical 4a. Fecility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **X**□M 2□F Yrs. 194-82-8781 Director 38 29 12 Tanzania 67 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits Item 27 ie marked other than "natural", or Itema 23a or 28e-f ehow other traumatic event, the Modical Exactinal must be notified at Director 1 ☐ Yes 2 XNo Windsor Mill Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 7410 Chadwell Cir Apt 203 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Tanzanian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Church Priest 12th grade 6yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anastazia Msonge Edward Bagwele ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7410 Chadwell Cir Apt 203, WindsorMill, M Md f Heelth Evod Shao-Friend 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/06 Arusha, Tanzania U.S.A. River 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md al 21215 23a. Part1. Enter the disease, or complement that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CARCINOMA OF THE COLON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transIt resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Completed 1 Yes 3 Probably 4 Unknown peeu Was a autopsy performed? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No hes this certificete 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2**X** No ဥ 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death
1 ki Natural
2 ☐ Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) October 12,2006 D0017695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELOU, ABDALLAH J. M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date liled (Month, Day, Year) 32. Signature State OCT 1 7 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32812 Amend Items 1,24a,25 per Min 6860,18617/06dhb Decedent's Name (First, Middle, Last) 2. Date of Death MOHORN, ALBERT Albert Mohorn Month Year **Physician** 7: 15 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNSHOPANS BAYVIEW MEDICAL BALTIMURE BALTIMORE CITY EVIER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 038-22-9626 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location treumatic event, the Madical Examiner nest be notified at MD Baltimore 1 oyes 2 □ No **Funeral Director** 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Street Apt.121 S. Clinton USA or Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after of Hygiene.
I Hygiene.
I other than "natural", or Ite. 1 toles: 1 toles: 1 toles: 1 toles: 1 toles: 1 toles: 1 toles: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housing MD 12th grade -years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental ! Pages 1 end 2 should be Albert J. Mohom, 8r. Owens vene ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2455 Union Blvd. Apt. 4K Sandre Monon item 27 other tre Islip, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 MBurial 2 □ Cremation 3 □ Removal from State King Memorial Park Windsor Mill, MD 10.12.06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Villy R. C. Greene Funeral Sewices
49.05 York Koad Baltimone MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 DAYS Examiner HYPOXIC BRAIN INJURY S. quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Year

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 24a. Was an

Probably 4 □Unknown

autopsy performed? 1 Yes **X**☐ No 26. Place of Death | Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No 27. Manner of Death

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

9 Unknown

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Hospital: 28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. VENKATESH MURTHY MD

RESIDENT PHOLCIAN

29c. License number

29d. Date signed (Month, Day, Year)

Z006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VENKATESH MURTHY, 4940 EASTERN AVENUE, BALTIMORE, MD 21224

31. Date filed (Month, Day, Year) State OCT 1 7 2006 Registrar

32. Registrar's Signature

Drivin 17 Rev 1/2001

should be detached

peeu

has

this

nours efter death.

neral Director: After this filled in by the funeral di

To the Hoepital within 24 hours a To the Funeral C completely filled Hospital

Division of Vital Records,

or Attending Physicien:

Completed by

Certification: To Be

Medicai

			For State		State	of Marylai		artment of H ertificate of L		<i>l</i> iental Hyg	iene 2 N C	06 32813
			Registrar     Decedent's Name	e (First, Middle	Last)			Timoato of L	Jean	2. Date of Deat		3. Time of Death
	Physicia		Mary Pau		,	•				Month October	Day 12	Year 2006 5:45 AM M
	/Medic Examin		4a. Facility Name (II					4b. City, Town, or	Location of Death	1 +	4c. County	
		•	Greater	Baltimo	re Medic	al Cent	er	Towson			Baltin	more
1	Funeral		5. Social Security N	umber	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs		If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
ы	Director		218-12-7		ILIW 2124F	89	Yrs.			08-16-	1917	MD
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Maryl f sho led a	ō	MD	Ra1t	imore		Timo	nium				1 □ Yes 2X No
	the 1	rect	10e. Street and Nur		Imore		111110	10f. Zip Code		1	0g. Citizen of W	Vhat Country?
	3a ol	Funeral Director	36 Sout	hwark F	Bridge Wa	v		21093			U.S.A	
	death	ner	11. Marital Status			cedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race	e - American Indian,
20	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Marri 3 █ਿWidowed			2 🔀 No live		1 ☐ Yes 2 ☒ No	Specify:	riicari, etc.)	Specify	k, White, etc. white
2-003o	72 hor natura dical E	Completed	(Spec	15. Decedent	s Education t grade completed	)	(Give	edent's Usual Occup	during most of worl		16b. Kind of Bu	usiness/Industry
Ž	ithin ne.	mple	Elementary/Seco		<del> </del>	(1-4or 5+)	`life.	DO NOT use retired	1)	9		
7	lled w Hygien her ti	Ö	8 17. Father's Name (	Eiret Middle	act)		Gr	ocery Cas		ne (First, Middle, N		Industry
yiand	ntal hed ot	Be	Frank Sa		.asi)				Alice I		vialueri Surriarri	ie)
Š	hould Me mark	ဥ	19a, Informant's Na		in (Type, Print)		19b. Mail	ing Address (Street			City or Town	State, Zin Code)
Z Z	th er		Mrs. Lin			htor		Southwark				, , ,
a)	s 1 ar f Неа ltem (		20a. Method of Disp	oosition		20b.	Place of Disp	osition (Name of ematory or other place	i			City or Town, State
<u> </u>	Page lent o nt: If ry or		1 Donation		3 □Removal from necify)	State Ce	-	11 Cemete		16-2006	Brook1	yn Park, MD
pairimoi	mit. partm porta y inju		21. Signature of F	neral Servi	licent e	.00	1 2	22. Name and Addres	ss of Facility S	ingleton	Funera	1 Home, PA
מ	De la la la la la la la la la la la la la	k di	Jun	1400	Toll	111013	641	1 Second	Ave SW; (	Glen Burr	nie, MD	21061
	35		23a. Part1. Enter the shock, or hea	he disease, or rt failure. List	complications that	each line.		nter the mode of dyin				Approximate Interval Between
	Physician		Immediate Cause (	Final n	Resy	mater	y 1 ai	lune 20 4	o ana	sarca	~	Onset and Death
	/Medical Examiner		resulting in death)	1	Due to	(or as a conse	wi noa of):	lue 20 t	4 50			. ,
	Lxammer	-	Seque stally list co.	rattione,	b. Sev	o (or as a conse	gulance of):	heard	Janeur	ll		weeks.
	ted nsit	Examiner	if any, leading to im cause. Enter Unde Cause (Disease or	rlying injury	Due it	7 (01 83 & 001136	quence on.		V			
,	executed in and iaf-transit	xar	that initiated events resulting in death) L		c Due to	o (or as a conse	quence of):					
28/20	ficate be physicial the buri	edical			d							
ô	tificat ig phy as th											
S C C	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent			utcome pf pregr		☐Ectopic pregnancy	,			te of delivery
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 1 ☐ Yes 2 <b>}</b> 9 ☐ Unknown	QNo		gnant at time of		Other (specify)			Moi	nth Day Year
7	that hed by deta		Part II. Other signif	icant conditio	ns contributing to	death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tot	pacco use contr	ribute to the cause of death?
ecords,	quires in sign	d by	Jone	stand	ing de	aletis	- me	elitus		1 □ Ye	es 2 No	3 ☐ Probably 4 ☐ Unknown
ပ္သ	s bee	Completed	Hym	tersio	$\sim$ 0					24a. Was a		Were autopsy findings available
	The la	mo	Hy .06	· linid	0 ,40, 0					autops perforr 1 Yes 2	ned?   c	orior to completion of cause of death? I □ Yes 2 □ No
VII III II	fan: rtifica stor, p	Be C	25. Was case refer examiner?	red to medical					26. Place of Dea	th (Check only on		
_	nysic nis ce direc	To E	1 ☐ Yes 2	No	Hospital: 1	Inpatient 2	□ ER/Outpatie	ent 3 DOA Oth	4 LI Nursing H	ome 5□Reside	ence 6 DOthe	er (Specify)
0	ng Pl		27. Manner of Deat	h 5 □ Pending	/8.80	e of Injury onth, Day Year)	28b. Time Injury	Worl		28d. Describe ho	w injury occurr	red
<u> </u>	tendi eath. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ation		L .		Yes 2 ☐ No	201 1 11 12		
DIVISION OF	after d after d Direct d in by	Certification:	4 ☐ Homicide	determi	200. Flat	ding, etc. (Spec	nome, tarm, s	treet, factory, office		City or Town	reet and Number, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)		Examiner: On the			ath occurred at the tir				anner as stated. and due to the cause(s)
	o the o the omple	Mec	29b. Signature and	title of certifier	and Ma	anier stateu.		29c. Licens	e number	2	9d. Date signed	d (Month, Day, Year)
	F \$ F 6		1	a til de	att- So	, mos	>	72	6250		10/12	12006
	1		00 Name and add			ion of double /lan	00a) /Tuna	Drint)				
/			M. SO. A	is, E	BMC,	6701 1	U. CHA	HRLES	ST, B	ALTIMO	ORE, A	w. 21204.
	Sta		31. Date filed (Mon	th, Day, Year)	32.	Registrar's Sign	nature	last a				
	Registr	ar		ICI17	ZUUD /	Septem .	10.	JE STORES AND				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 006 32814 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 455 Frank Edward McGee Jr. PM 2006 october /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ff Under 1 Year If Under 24 Hrs. LORIEN IVERSIDE ARFORD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-18-6113 81 Director Feb. 15, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumaric event, the Medical Examinar must be rigitized at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 951 G Richwood Rd. 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: KOƳe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: Completed by 3 Widowed 4 Divorced Korea White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Railroad 18. Mother's Name (First, Middle, Maiden Sumame) しいに 17. Father's Name (First, Middle, Last) Be and N ental Frank Edward McGee Sr. Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Lufburrow/ Friend 33 Bonnie Ave., Bel Air, Maryland 21014
lace of Disposition (Name of Date 20c. Location - City o Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö tX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Western Cemetery 4 □ Donation 5 □ Other (Specify) 10-21-06 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MCComas Funeral Home, P. A. TM 50 West Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complicated a that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Finaf disease or condition resulting in death) Physician ras a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available phor to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 100 25. Was case referred to medical examiner? Be 26. Pface of D ath Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 12 No 1 | Inpatient 2 | ER/Outpatrent 3 | DOA s after death.

I Director: After this d in by the funeral d 27. Man of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number cause of dea v (Item 23a) (Type, P anue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Day **Physician** , 2006 (0:53 AM october Donald Frederick Meushaw /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 10, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 215-34-1243 71 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland ment of Hauth and Mental Hygiene.
The filem 27 is marked other than "naturel", or Itams 23a or 28e-1 show ant: If item 27 is marked other than "naturel", or Itams 23a or 28e-1 show any or other traumatic event, The Modical Experiment and per published as 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Benson Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County Government Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas H. Meushaw Thelma V. Shumaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Arlington Ave., Boltinore, MD 21227

20b. Place of Disposition (Name of Department of other place)

Meadowridge

10-17-2006 Filtridge MD <u> Douglas Meushaw - Brother</u> 20a. Method of Disposition X□Burial 2 □Cremation 3 □Removal from State permit. Page Deportment of Important: If any njury or once. 10-17-2006 `4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD Memorial Park 10-1/-2000 LIKINGE, ID
22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septic shock /Medical Examiner Klebsiella Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherorelevoris

24a. Was an autopsy performed

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2□No 26. Place of Death (Check only one)

25. Was case referred to medical 1 Yes 2 No 27. Mannes of Death

1 Natural investigation 2 Accident 6 Could not be determined 3 🗍 Suicide

1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certification: To 29a. Certifier Medical (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4 Homicide

m 9 C, 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0052540

Registrar

Thomas E. Enelow-St. Agnes Hospital - Baltimore Maryland 31. Date filed (Month, Day, Year)

within 24 hours a

PUSHEL

1000 (S

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene 2006 32816

		1- For State Registrar		Cer	tificate of	Dea	th			R	eg. No	2	101	) )	201
Physici	an/	Decedent's Name (First, Mid-	ame (First, Middle,Last) Pame a Marie Knight 2. Date of Death 3. T									3. Time of D	eath		
edical Exami			PAMELA	MARI	E McKI	IIG	<del>IT</del>		ď	fonth ctober 1	4, 20	06 Year		2105 h	rs
		4a. Facility Name (if not institut	on, give street and number	)	4	b. City,	Town, or	Location of De				. County o	Death		
		Sinai Hospital				Balti	more					CIT	ľΥ		
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. la	ast birthday)	If Un	der 1 Yea	r If Under 24	Hrs. 8.	s. 8. Date of Birth (MM/DD/YYYY) 9. Bir					or Foreign
Director		220-82-9413	1 M 2 X F	1	3 yrs.	Mont	hs Day	s Hours I	Min.	17/2	3/1963   Country) MARYLA				AD.
			1 M 221 F		3 Yrs.		Ш.,			01/2.	J / I	903	1.17-	. IV T 1141	4D
any		Usual Residence of Decedent  10a. State 10b. County	,	10c. City.	Town or Locati	on						-		10d. Inside	City Limits
<b>*</b>			TY	,	BALT		ישסר							1 X Yes	
land f sh	ţō			L	י האינו								لــِــا		
Mary 28a- d at	Director	10e. Street and Number				10t. Zi	p Code			1	0g. Cit.	izen of Wha	at Coun	try?	
the 3a or		910 SULGRAY	/E AVE., AF	T 1		2	2120	9		- 1	Ū	SA			
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	12. Was Deceden Armed Forces					panic Origin? , Mexican, Pue			-			an Indian, B	lack,
death r ite	un	1 Never Married 2		X No	" "	es, spec	lly Gubar	, Mexican, Put	ento Rica	in, etc.)		White			
ufter II", o	by F	3 X Widowed 4 D	ivorced If Yes, Give Year or Dates:		1	Yes :	2X No	specify:				Specify:	WHI	$\mathrm{TE}$	
21215-0036  Juld be filed within 72 hours after Mental Hygiene marked other than "natural", e event, the Medical Examiner		15. Decedent's Education (Sp		npleted)	16a. Decedent					done	16b. i	Kind of Bus	iness/Ir	ndustry	
n "na al Ex	Completed	Elementary/Secondary (0-12	) College (1-4 or	5+)			-	DO NDT use	retired)						
D36 thin than than	ldu	12			FACTO	PRY	WOR	KER			M	ANUF.	ACT	URING	3
d wi	ટુ	17. Father's Name (First, Middle	e, Last)					18.Mother's Na	me (Fin	st, Middle, I	Maiden	Surname)			
21215-0036 wild be filed within 7 Mental Hygiene marked other than	Be (		CLARENCE	V	OGEL			MILI	DRE	)	EL	SROA	D		
21; ould b Men mar	0	19a Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Addres	s (Stree	t and Number	or Rura	Route Nun	nber, C	ity or Town	, State,	Zip Code)	1157
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland an of Heath as Mental Hygiene Trie. I fitem 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once other traumatic event, the Medical Examiner must be notified at once		SHEILA BUETT	NER – A	UNT				STMINS						_	
and and fealth		20a Method of Disposition		20b. F	Place of Disposi	tion (Na	me of cer		Da					Town, State	
MOre Pages I nent of F ant: If i		1 Burial 2 X Cremation	on 3 Removal from St	ale	rematory or oth	•			4.0	14-16	_				
<b>C</b> 0 9 5 5		4 Donation 5 Other		HTT	COUNT										MD
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiener Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service	e Licentee	6				of Facility I							
		1) Jamy 11	y digit					IN ST							
Physician		23a. Part I. Enter the disease, of failure. List only one cause	e on each <del>lin</del> e.	the death.	Do not enter tr	e mode	of dying,	such as cardia	ac or res	piratory arr	est, she	ock, or hea	rt	Approxima Between (	ite Interval Onset and
/Medical Examîner	ê H	Immediate Cause (Final diseas	e a Intracereb	ral her	rorrhage									De	ath
į		or condition resulting in death)	Due to (or as a cons	•				-							
and the same of th	L	Sequentially list conditions,	b. Hypertensi			tic (	cardio	vascular	dis	ease			_		
	Examine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of	1):										
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	f):										
uted Id ansit		a committee of the comm	d.												
(ecords, P.O. Box 68760), The law requires that the death certificate be executed are has been signed by the attending physician and mage 2 should be detached for use as the burial - transit	n/Medical	X UNPENDED	AMENDED23a-	h 27 m	ME -061	11 /	2/04 1	TI						-	
50, te be nysici	Jed	IF FEMALE:	#23d	me of preor	SILE GOOT	,11/4	2/00 1	.1			23	d Date of o	lelivery		
8760, rificate be ng physic as the burn	Ž	23b. Was decedent pregnant in				al death	3	Ectopic pre	gnancy		23	Month	,	ay	Year
x 6 h cer tendi	icia	past 12 months?	4 Pregnant a		oth	ner (Sp								-	
Box 687.  The death certification is the attending price as the	Physicia	1 Yes 2 No 9 V U	nknown 9 Unknown												
P.O. s that the sned by detach		Part II. Other significant cond	itions contributing to deal	h but not re	esulting in the u	nderlyin	g cause g	iven in Part I.		23e. Did to	bacco	use contrib	ute to t	ne cause of	death?
Vital Records, P.O. hysician: The law requires that this certificate has been signed but director, page 2 should be detaed	d by								_	1 Yes	2	No 3	Proba	ably 4 🗸 l	Jnknown
Division of Vital Records, rate and rate of Atlant and Atlanta Physician: The law requiring the rate of the rate o	Completed								- 1	24a. Was				opsy finding	
CO law has	lαμ			· · · · · · ·					-		rmed?	de	or to co ath?	mpletion of	cause of
	S									1 🗸 Yes	2N	0 1	✓ Yes	2	No
tal	Be	25. Was case referred to medic examiner?	Line and all					of Death (Che							
Whysial dir	၉	1 Yes 2 No	I Inpati		ER/Outpatient	-	DOA		rsing Ho	housest		ence 6	Other		
n of J ding Ph After t funeral		27. Manner of Death	28a. Date of Inj (Month, Day,)	ury Year)	28b. Time of Ir	ijury		y at Work?	28d	Describe I	how inji	ury occurre	d		
ion tend eath. tor:	ati		nding estigation				11	res 2 No							
ivisior t or Attend after death Director:	<u>i</u>			njury - At ho	me, farm, stree	t, factor	y, office b	uilding, etc.	28f.			ind Number	or Rur	al Route Nur	nber, City
Division pital or Attentours after deatheral Directors	Certification:	4 Homicide det	ermined (Specify)							or Town, S	iale)				
Hosp 24 ho Fune tely f	<u>a</u>	29a. Certifier (Check only 1 Certifying I	Physician: To the best of m	y knowledo	ge, death occur	ed at th	e time, da	ate and place, a	and due	to the caus	e(s) ar	id manner a	as starte	ed.	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after detter. After this centif To the Funeral Director: After this centif completely filled in by the funeral director,	Medical	one) 2 Medical Ex	aminer:On the basis of exa and manner stated	ımination aı	nd/or investigat	on, in m	ny opinion	, death occurre	ed at the	time, date	and pla	ace, and du	e to the	cause(s)	
F 2 8	Me	29b. Signature and title of certif				29	c. Licens	e number			29d.	Date signe	d (Mon	h, Day, Year	)
		101.	1000				O.C.I	M.E.			Oct	ober 16,	2006		
		30. Name and address of person	n who completed source of	doath /Itom	239)				-						
-		Zabiullah Ali, M.D.	Assistant Medical E		-	n Stre	et. Balt	imore, MD	21201						
							, _unt		0 1						
Pogis	tate	5 Jak mod (Month, Day, real	, salkegistie	o oignatu	1										

State of Maryland / Department of Health and Mental Hygien (1) 6

1- State Amned item#2, perMD, g860, 10/26/06 TT Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Meyd 7-9 3.45-PM Charles 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hom Columbia NUVSE Howard Lovien If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min **™** M 2□ F Yrs. 219-01-9376 Director 03/04/1921 MD Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 28e-f show event, the Medical Examiner owest he notified at 1 Yes 2 No Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5520 Selma Ave. 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene.
I Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White à Specify: 3 Widowed 4 Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinist Westinghouse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lightly or other traumatic event, and B. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jerome Meyd Anna Kapraun 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Francis Meyd, JR / Son 20801 Slab Bridge Road, Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Madwridge Memorial Park 10/11/2006 Elkridge, MD Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostale Concer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to lum ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Records, P.O. Box 68760. Physician/Medical the 35 attending for use as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. М 1 Tyes 2 No investigation after death Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospitel Certifying Physician: To the best of my knowledge death occurred at the time state and places and direct, the cause (s) and manner as stated 29a. Certifier Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 10/9/06 DUUS3709 (our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENIE MI FUX lon SIE 14300 Gallow CHAWLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No.	2006 32818
			Decedent's Name (First, Middle, Last)     2. Date of Death	3. Time of Death
	Physici /Medi			
	Examir		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c.	County of Death Butti City
	Funeral Director		5. Social Security Number 6. Sex 1. Age (Ith yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 Months Days Hours Min. 09 17 1	9. Birthplace (State or Foreign Country)  QUE DOUTHWAY MIN.
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Manyli f sho	jo		1 ☐ Yes 2 XNo
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citi.	zen of What Country?
	23a o			ited States
	ems erm	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, etc.
215-0036	hours after death with the Maryland turel', or Items 23a or 28a-f show at Examiner must be notified at	by	3 XWidowed 4 □ Divorced	Specify: White
2	72 hours "naturel", Urcel Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	nd of Business/Industry
7	be filed within 72 hr tal Hygiene. d other than "natu	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	
Z	be filed v tal Hygie d other t			othing Sumama)
land	ld be filed ental Hyg ked other ic event,	To Be		Junamen
ary	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	· Town, State, Zip Code)
Σ	カモトン		Irene L. Winters (Pers. Rep) 108 Pinecrest Drive, Annapolis, M	
Baltimore	of H of H if ite		1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State   cemetery, crematory or other place)	cation - City or Town, State
E	permit. Pag Department Important: any injury conce.		'4X Donation 5 □ Other (Specify) Bayview Crematory 10/16/2006 Bal	timore, Maryland
ğ	permit. Pag Department Important: I any injury o		21. Figure and Address of Facility Hubbard Funeral 4107 Wilkens Avenue, Baltimore	l Home, Inc. e, Marvland 21229
â	1780 17 m		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
,	Pnysician		Immediate Cause (Final disease or condition a. Demien (A.	Onset and Death V-C UV J
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	hiseme Venvi
d	N 1 94 L	ler	Sequentially list conditions, if any, leading to immediate b. Artereosclerotic Carcinovascular of Due to (or as a consequence of):	viseme years
	cuted	Examiner	Cause (Disease or injury that initiated events	
Š	ate be executed hysician and the burial-transit			
09/80	cate b physic the b	dical	d	
٥ ۲	death certific e attending p id for use as	Physician/Me	FFEMALE: 23c. If yes, outcome of pregnancy 2 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 2	3d. Date of delivery
. BOX	death e atter	iciar	in the past 12 months?  1	Month Day Year
r Ö	at the by th	hys	9 Unknown 9 Unknown	
cords, I	requires that the death certific een signed by the attending p hould be detached for use as	by	Part II. Other significant contributing to death out not resulting in the underlying cause given in Part I.	se contribute to the cause of death?  No 3 Probably 4 Unknown
eco	> 0	ojete	24a. Was an	24b. Were autopsy findings available
Ž	The ate h page	Completed	autopsy performad?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
VIII H	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
=	this al di	<u>د</u>	The state of the s	
0	iding Ph th. : After th funeral	tion	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 27 Accident Investigation 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2 No	occurred
UIVISION	al or Attending P s after death. if Director: After t id in by the funera	Certification:	2   Suicide   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and building, etc. (Specify)   City or Town, State)	Number or Rural Route Number,
5	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer			
	ie Hos 124 hc ie Fun iletely i	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	and manner as stated. place, and due to the cause(s)
	To th withir To th	M	29b. Signature and title of certifier 29c. License number 29d. Date	signed (Month, Dey, Year)
	J		055341 Octo	ber 12,2006
	5		Ming V, 3320 Benson Avenue, Baltimore, Marylan	
4	Sta	_	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Registr	ar	The second second	

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of rtificate of			2006	32819
	ysicia Medic	_	Decedent's Name (First, Middle, Lass	BETTY IRE	NE NAI			2. Date of Death Month OCT . 13	Day Year 3, 2006	3. Time of Death
	amin eral		4a. Facility Name (If not institution, give  728 CINDY LANE  5. Social Security Number 6. Se		rs. last birthday)	WEST		R	4c. County of Deat  CARROL  9. Birt	L hplace (State or Foreign
Dire	ctor		220-26-5676  Usual Residence of Decedent  10a. State  10b. County		75 Yrs.  City, Town or Lo	Months Days	s Hours Mi	s. Date of Birth (Month, Day, ) 10 / 21 / 1	930 MAI	RYLAND  10d. Inside City Limits
the Maryla 28a-f ebov	notified at	Director	MD CARROLL  10e. Street and Number		ESTMIN			100	g. Citizen of What Co	1 ☐ Yes 2 💆 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 le marked other then "natural" or items 23a or 28a-f show	nat must be	Funeral Di	728 CINDY LAN  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.		21157	(Specify Yes or No- erto Rican, etc.)	USA  14. Race - Ame Black, Whit	arican Indian,
21215-0036 Id within 72 hours att giene.	dical Exem	þ	3 ☑ Widowed 4 □ Divorced  15. Decedent's Edi (Specify only highest grad		16a. Dece	1 ☐ Yes 2 💆 No dent's Usual Occi kind of work don	upation e during most of w	vorking 16	Specify: WH	ITE Industry
e fited within I Hygiene.	vent, the Mo	Be Completed	Elementary/Secondary (0-12)  1 0  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	DO NOT use retir		ame (First, Middle, Ma	aiden Sumame)	
Maryland of 2 should be file th and Mental Hy 27 le marked oth	reumatic e	To E	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Stree	et and Number or i		City or Town, State, 2	<sup>Zip Code)</sup> 21787
Baltimore, Normali. Pages 1 and Department of Heelth moortant: If them 27	ıry or other t		LARRY E. NAILL  20a. Method of Disposition  1 ÄBurial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	iomovai iroini State	o. Place of Dispo cemetery, cre-	osition (Name of matory or other pl		17/06	HWAY, TA  Oc. Location - City or  NIONTOWN	
Balt permit. Departr	eny Inju		21. signature of principal Service Licens 23a. Partl. Enter the disease, or comp		25	54 E. M	AIN ST.	,WESTMIN	STER, MD	HOME, P.A. 21157 Approximate
Physic /Med	lical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a cons	J ()	No	_		•	Interval Between Onset and Death
760, te be executed with the e	ral-transit	ical Examiner	Sequentially list conditions, if any, leading to miniocial cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	b						
.O. Box 6: the death certific y the attending p	iteched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3[	Ectopic pregnan Other (specify)	су		23d. Date of del Month	ivery Day Year
ords, Poquires that	9	<u>م</u>	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying cause g	oven in Part I.		cco use contribute to 2 ☑ No 3 ☐ Pr	the cause of death?
al Records, 1: The law requires t icate hes been signe	. page 2	Completed						24a. Was an autopsy performe 1 Yes 2	prior to death?	itopsy findings available completion of cause of
		ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 16  27. Mann Peath 1 atural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatier 28b. Time o	f 28c. Inju	ther: 4 🗆 Nursing	Home 5 X Resident 28d. Describe how		cify)
DIVIS Hospitel or Atte to hours effer de Funerel Directo	led in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str scify)	reet, factory, office	3	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
To the Hospitel within 24 hours e	completely filled	Medical	29a. Certifier (Check only one)  21 Medical Example of Certifier (Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death oc	curred at the time, date	se(s) and manner as and place, and due	to the cause(s)
- 5 -			30, Name and address on programme and address on the contract of the contract	ompleted cause of death (I	tem 23a) (Type,	Print)	5303	1 /	0/16/0	6
, Re	Stat egistra	te ar	31. Date filed (Month, Day, Year)	32. <b>Ri</b> gistrar's Sig	SOUT gnature	(cnti	n H	reet IV	cstmunsto	IND SIZ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 8 per fg g860 10-26-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32820 06 Certificate of Death 1. Decedent's Name (First, Middle, Last) Nickoles Cecilia Ann 2. Date of Death 3. Time of Death Month Year **Physician** 1916 October 15 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayview City Medical Center Baltimore N/A Hopkins It Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 57 Yrs. 5. Social Security Number 6. Se Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2√2 F 213-52-2816 Usuat Residence of Decedent Director Feb Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 ☐ No N/A Baltimore MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA Funerai 6733 Bessemer Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No tf Yes, Give X Year or Dates: 1 ☐ Never Married 207 Marned 1 ☐ Yes 2 ☑ No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Homemaker Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Zygmunt Elizabeth James Knozek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Nickoles - Husband 6733 Bessemer Ave. Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St.Stanislaus Cem. 10-19-06 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, 1201 Dundalk Avenue Baltimore. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Fart1. Enter the diseas shock, or heart tailurg. e, or com Immediate Cause (Final disease or condition Respiratory hours resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Examiner Due to (or as a consequence ot): Physician/Medicai PIRMYA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 2 🗆 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, ed by the e should be peen page 2 s has certificate To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

with the Maryland

death v

Saltimore, Maryland 21215-0036

item 27 is marked other then "netural", or iteme 23e or 28e-f show other traumatic event, the Madical Examinar injustice notified at

permit. Peges 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 ie marked other eny injury or other traumatic event.

**Physician** 

/Medical

State Registrar

Medicai

Santosh Opmmen 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

29a. Certifier

M.O.

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2006

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

4940 Avenue, Baltimore

Eastern 32 Registrar's Signature

		ľ	for State Registrar	State of Ivia	ryiand		rtificate of		ı Mental Hy	_	2006	32821
		N	Decedent's Name (First, Middle, La.	st)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		James 1	Edward		O'Rou	rke		October	Day		2:30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of De			County of Death	
		0	Gilchrist @ G.B.M	1.C.			Towson				Baltimor	e
	Funeral		Social Security Number 6. S			st birthday)		If Under 24 Hi		th V Year)	9. Birth	place (State or Foreign ntry)
	Director		210-20-4009	<b>X</b> M 2□ F	75	Yrs.	I Nontrio	Tiodio IVIII	June 28	3,193	31 Penn	sylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	1	10c City	Town or Lo	ncation					10d. Inside City Limits
	laryla sho	Funeral Director	Maryland Baltimon			Notti						1 ☐ Yes 2 ☐XNo
	the M		10e. Street and Number	.e		NOCCI	10f. Zip Code		Т	40		
	a or	ē	4305 Mispillion Road				21236				zen of What Cou USA	ntry?
	eath	era	11. Marital Status	12. Was Decedent E	ver in U.S	13			(Specify Ves or No		14. Race - Ameri	can Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 Note Note Note Note Note Note Note Note			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		erto Rican, etc.)		Black, White, Specify: Whi	etc.
9	72 ho natur lical	Completed by	15. Decedent's Ec	lucation	- 1	16a. Dece	dent's Usual Occup	ation	vorkina	16b. Kir	nd of Business/In	dustry
2	thin an ". Med	nple.	Elementary/Secondary (0-12)	College (1-4or 5+	)	life.	kind of work done DO NOT use retired	d)	Orking			
7	ed wi ygien er th	Sol	12 years	4 years		Ins	urance Ac					Insurance
nd	be file	e ·	17. Father's Name (First, Middle, Last)						ame (First, Middle,	Maiden	Surname)	
<u>y</u> a	Men Men arke	2	John O'Rourke					Joseph	ine Weis			
a	2 sho		19a. Informant's Name/Relationship (				ng Address (Street			-		,
	and lealth m 27 her tu		Dorothy O'Rourke	wife			Mispilli					
Baltimore,	Pages 1 Iment of H Iant: If ite jury or ot		20a. Method of Disposition  1   ☐ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify)		1	k Law	sition (Name of matory or other place n Cemeter	У	ober 16, 2006	Dunc	cation - City or To	•
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	(onne	ll		2. Name and Addre Onnelly F 110 Solle	rs Poin	t koad, t	Junaa	alk,P.A. alk, MD.	21222
i.	¥		23a. Part 1. Enter the disease or complications that caused the death. Re not enter the mode of dying, such as cardiac or respiratory errest.  Approximate									Interval Between
	Physician	1	Immediate Cause (Final disease or condition	LVNG		anco		. \				Onset and Death
	/Medical		resulting in death)	Due to (or as a				•				101.3
	Examiner		Sequentially list conditions									
15	₽ #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):						
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
Š,	e ex	۵	Toodising in docum, Educ	Due to (or as a	conseque	consequence of):						
68760,	ate b	edical		d								
_			IF FEMALE:	00- 11		_			<u>-</u>			
Bo	attend for us	Physician//	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	Fetal	death 3	Ectopic pregnancy	/		2	23d. Date of delive Month	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at t 9⊡Unknown	ime or dea	ain 5∟	Other (specify) _					•
٥.	that the		Part II. Other significant conditions of	ontributing to death but	not result	tina in the u	nderlying cause give	en in Part!	23e. Did to	obacco us	se contribute to t	he cause of death?
Records, P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	d b	2.								2□ No 3□ Probably 4□Unknown	
Ö	w req been shou	Completed							24a. Was		045 44	
Ä	S S S	d l							- autor	osy		psy findings available mpletion of cause of
Vital	n: Ti ficate rr, pa		OF West and the state of the st							rmed? 2 No	1 ☐ Yes	2□ No
	sicia certi recto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		D/O: t= -1'	t 3 DOA Oth	or:	eath (Check only o			1 0.1
ō	Phy r this ral d	2	27. Manner of Death	1 ☐ Inpatien		R/Outpatien 28b. Time of	I JU DON	4 🗆 Nursing	Home 5 ☐ Resid		-	y) NOSPICE
0	ding h. Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Injury				,,,				
Division or	Atter deal	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injur	y - At hon	ne, farm, str	eet, factory, office		28f. Location (5	Street and	d Number or Rum	al Route Number.
5	all or after	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or Tou	vn, State)	)	,
	To the Hospital or Attending Physician: The law requires that the death cei within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use		29a. Certifler  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	he He in 24 he Ft pletel	Medical	(Check only	and manner state	examination et al.	on and/or in	vestigation, in my c	pinion, death oc	curred at the time,	date and	place, and due to	o the cause(s)
	Vithi To ti	Ž	29b. Signature and title of certifier				29c. Licens				e signed (Month,	
}			Muam	~)			29	8303		OUR	wer 1	3 2006
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  African Charles in 6601 N. Charles it Marinne in 2124									
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	's Signatu	ire 🧳	20					
	Registra		OCT 1 7 200	16 Par 2000	a All	63						

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland /		artment of H		-	giene 0 0	6 32822	
表	Physici /Medic		1. Decedent's Name (First, Middle,	-	ven.	Jr.			2. Date of De Month	Day Ye		
)	Examin	-dir	4a. Facility Name (If not institution, Wilson Heath Cou  5. Social Security Number	e Center	e (in yrs. last	birthday)	4b. City, Town, or Court Le	If Under 24 Hr	ath	4c. County of [	Death Sethplace (State or Foreign	
*	Director	Months Days						Hours Min. B. Date of Birth (Month, Day, Year)  March 19, 1920  9. Brithplace (State or Foreign Country)  Washington				
altimore, Maryland 21215-0036	Pages 1 and 2 should be tiled within 72 hours after death with the Maryland near of Health and Mentall Hygiene. And the time 27 is marked other than "natural", or items 23a or 28a-f show nnt: if tem 27 is marked other than "natural", or items 25a or 28a-f show ary or other traumatic event, the Modical Examinar mist be notified at	ctor	Maryland Montg	omery	10c. City, To		thersburg	<u> </u>			10d. fnside City Limits 1	
		i Directo	10e. Street and Number 415 Russell Avenue #109 10f. Zip Code 20877					<i>-</i>		10g. Citizen of Wha	,	
		To Be Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Never Married 2 Married   12 Yes 2 No   17 Yes, Give Year or Dates 1940			If Yes, specify Cuban, Mexican, Puèrto Rican, etc.)				14. Race - American Indian, Black, White, etc.  Specify: White		
			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Naval Officer						rorking	16b. Kind of Business/Industry Federal Government		
			17. Father's Name (First, Middle, Last) Thomas B. Owen, Sr.					18. Mother's Name (First, Middle, Maiden Surname)  Ruth Deane nd Number or Rural Route Number, City or Town, State, Zip Code)				
			19a Informant's Name/Relationsh Catherine A. Ow			P.O.	Box 628,		ez, Calif	ornia 945		
			20a. Method of Disposition 1 □ Burial 2 X Cremation 4 □ Donation 5 □ Other (Sp		ceme	etery, cren	sition <i>(Name of</i> natory or other place <b>Crematoriu</b> n	OCIC	ober 17,	Bethesda,		
Balti	permit. Page Department Importent: if any injury or once.		21. Signature of Funeral Service L	-	MOO198	22	Name and Address	e of Eacility		Home/Roc	-	
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that caused	the death. De.	o not ente	er the mode of dying	g, such as cardia	ac or respiratory ai	rrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)							-		
	ate be executed hysicien and the burial-transit	icai Examiner	b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
	ath certific ttending p or use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
	w requires that the de been signed by the a should be detached t									d tobacco use contribute to the cause of death?		
r									24a. Was autop perio 1 □ Yes	an 24b. Were prior deat 2 2 2 4 1	e autopsy findings available to completion of cause of h?	
r Vital	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1								Specify)	
ion of	or Atten fter deat Director: in by the	Certification: 1	27. Manner of Death    Matural   S   Pending   Investigation     Accident   S   Suicide   A   Homicide   S   Homicide   S   Place of Injury   28b. Time of									
DIVISION		Certifle									r Rural Route Number,	
	the Hospitel hin 24 hours a the Funerel ( mpletely tilled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	Tot Tot		29b. Signature and title of certifier  29c. License number						29d. Date signed (Month, Day, Year)			
	2071		30. Name and address of person w	no completed cause of de	ath (Item 23	a) (Type, I	Print)		- 10		1 2000	
16 17	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	SLLL r's Signature	Ne	Carthers	burg	MIZ Z	0877		
A STATE	Registr	ar	OCT 17	2006	48.5 30	· ASS						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10 06 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death **Examiner** onlar Tospurce umore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**√**F Days 218-26 tumore Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☑Yes 2 No Director tumore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be owlers 0 ပ Print) 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Saeruson Fóres 23-06 4 □ Donation 5 □ Other (Specify) 10 -21. Signature of Funeral Service Licensee 22. Name and Address of Facility mo1215 1 East Chare 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknow þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t autopsy certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Wher (Specify) 1 ☐ Yes 2 DeNo 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5

State Registrar Amen

M 6565 N

31. Date filed (Month, Day, Year) 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



curres

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day 3 2 006 **Physician** 5:25 pm Claude C. Parks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 28 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days <sup>Year)</sup>931 PA Country) Months Hours Min. 217-24-5028 1**X** M 2□ F 74 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore Director MD Middle River 1 X Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 19 S. Hawthorne Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married XYes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Construction 17. Father's Name (First, Middle, Last)
Joseph R. Parks 18. Mother's Name (First, Middle, Maiden Surname)
Dora R. Gilmore Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 S. Eleanor Schuler Sister Hawthorne Rd Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/16/06 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Avenue Balto MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that cause time death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dinbetic nep to patry disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the confirm Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director; / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 OCTUBER 14 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 horles un 32. Registrar's Signature State 7 2006 Registrar All Sales Sand

State of Maryland / Department of Health and Mental Hygien 2006 32825 For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Harry Pope, Sr. 7016 02.528 M OG6PEZ 5 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BE GIBN BURMIE If Under 1 Year If Under 24 Hrs. 8. Date BALTIMORE WASHINGTON MEDICAL CENTER Anne ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Director 220-12-9498 79 Yrs 12-10-1926 Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Directo Anne Arundel Glen Burnie 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Eugenia Avenue 21061 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Itel Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No <u>δ</u> Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Master Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Elmer Pope Alice Dorr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harry Pope, Jr. / son 400 Eugenia Avenue; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it eny injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Dothar (Specify) 10-17-2006 Glen Burnie, MD Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Fundal Service 1 Second Ave SW; Glen Burnie, MD 21061 M0136L 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between CANGER Onset and Death Immediate Cause (Final **Physician** unc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 nknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature an title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) tholer 12 2006 ed cause of death (Item 23a) (Type, Print) 30. Name and ad ress of person who comple Hospital drive 301 32. Registrar's Signature 31. Date filed (Month, Day, State Ï Registrar

State of Maryland / Department of Health and Mental Hygiens, For State Registrar 32826 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 14, Hazel Marie Parslev 2006 7:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health Care Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Yrs 214-26-2204 Director March 21, 1931 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28e-f show r then "naturel", or Items 23e or 28e-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Mary land Baltimore Baltimore Highlands Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 Pennsylvania Ave. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Item other treumatic event, Ita Medical Exercised 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Louise Benzinger Avery Henry White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu once. Susan Parsley, daughter 6107 Pine Crest Lane Frederick, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Druid Ridge Park 10-16-06 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Lansdowne, MD. 21227
Approximate
Interval Between
Onset and Death 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA ALZHEIMERS Physician /Medical Due to (or as a consequence of) Examiner CERESCOVAS CUL AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last poni EN510N been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 III No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ARTERY TORONAN. DIJEASE 1 Yes 2 No 3 Probably 4 Worknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA inis tor: After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Maturai 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours after the Funerel Dire ŏ the Hospitel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staled. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lapun areus, new. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTER St BALTIMORE, MIDZIZZ K.S. DHARMASENA, NOD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

		•	For State Registrar	State of Ma	•		rtment of H		Mental Hy	giene Reg. No.	2006	32827
	1		1. Decedent's Name (First, Middle, Last	)					2. Date of De Month	eath Day	v Yeer	3. Time of Death
	Physicia /Medic	_	Jennifer W.	Peterson	า				10	11	2006	7:00PM <sup>M</sup>
<i>j</i>	Examin		4a. Facility Name (If not institution, give 5559 High Tor Hi				4b. City, Town, or Colum		th	4c. County of Death Howard		
	Funeral		5. Social Security Number 6. Se		(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hr. Hours Min	. (Month, D	rth ay, Year)	9. Birtl	nplace (State or Foreign Unitry) Nales, GB
	Director		578.58.1850 Usual Residence of Decedent	JW 2028 12		Yrs.			06	21	19345000	II Wales, GB
	and ow	-	10a. State 10b. County		10c. City, Tow		cation					10d. Inside City Limits
	Many	tor	Md Howard		Colum	bia						1 ☐ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number				10f. Zip Code			_	izen of What Co	untry?
	ath wi	rai	5559 High Tor Hil			1	21045				USA	dana la dina
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	rto Rican, etc.)	0-	14. Race - Ame Black, White	
39	urs aft	by F	3 ⊋Widowed 4 □ Divorced	If Yes, Give	•0	1	☐Yes 2X No	Specify:			Specify: Bla	ıck
ğ	2 hou	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a.	Deced	ent's Usual Occup	ation	ndkina	16b. K	ind of Business/	Industry
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	ONOT use retired	1)	sining .	Gas	Service	Station
7	filed within 72 hours after death with the Maryland Hygiene. Sther than "naturel", or items 23s or 28s-f ehow ent, the Medical Examinar must be notified at	Ö	12. 17. Father's Name (First, Middle, Last)	2			211000		ame (First, Middle	1		Deactor
Maryland 21215-0036	id be fi ental H ked of ic ever	To Be	James Wilson						Birkett	,	, , , , , , , , , , , , , , , , , , , ,	
ary	and M mar mumat		19a. Informant's Name/Relationship (T	ype, Print)	19b		g Address (Street					
Σ	and 2 Balth in 27 I		Joelle Ness/Daugh	nter			9 High T	or Hill				
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.  Deperment of Health and Mental Hygiene.  Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show may injury or other traumatic event, the Macilial Examinar must be notified at any injury or other traumatic event, the Macilial Examinar must be notified at any once.		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			rv. cřen	sition (Name of natory or other place matory	10/	Date 13/2006		ocation - City or Onsville	
Balti	permit. Depertra Importa eny injk		21. Signature of Funeral Service Licens	ckman		555 555	Name and Addre	ss of Facility William	itzke Fu 1. Colum	neral bia,	l Homes Md 2104	Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lir	the death. Do	not ente	er the mode of dyin	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	. Uteri	ine (	201	ncer					Onset and Death  Year
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						l
		er	Sequentially list conditions,	b. Due to (or as:	a consequence	of):						
V	ot d d ansit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
o,	e exection and an arrial-tr		resulting in death) Last		a consequence	of):						
8760,	icate be executed physicien and s the burial-transit	dica		d.		-						
9 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of del	iverv
Вох	thet the death certificate be executed ed by the ettending physicien and deteched for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No	4□Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)	<i>+</i>			Month	Day Year
P.O.	by the	hys	9 Unknown	9⊡ Unknown		_			-			
of Vital Records, F	8 C 0	þ	Part II. Other significant conditions or	Intributing to death be	ut not resulting i	in the ur	nderlying cause giv	ren in Part I.		tobacco (		o the cause of death? obably 4 Unknown
000	aw require ts been si 2 should t	Completed							24a. Wa		24b. Were au	itopsy findings available
æ	0 - 0	mo							per 1 Yes	opsy formed? 2 No	death?	completion of cause of 2 ☐ No
/ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						eath (Check only	one)		
€ 0	\$ 5 D	P	1 ☐ Yes 2 No		ent 2 ER/O	utpatien Time of	I 3 DOA		Home SRes			cify)
	ding l h. After funer	tlon	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)		Injury	Wo	rk?  Yes 2 □ No	Zod. Describe	riow iiiqu	ny occurred	
Division	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined			arm, str	eet, factory, office			(Street ar own, State		ural Route Number,
_	Hoepital     24 hours e     Funeral i letely filled	dical Ce	(Check only 2 Medical Exam	ysician: To the best	f examination ar	e, death	occurred at the ti	me, date and pla opinion, death oc	ce, and due to the	e cause(s	and manner as d place, and due	s stated. to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Year)
	V V V		Mohu	E Juns	PHYS	icy	1	53590				13,2006
	1		30. Name and address of person who of	completed cause of d		(Туре,	Print) 624	NB	RUADUA	44	Li215	-110
	St	ate	31. Date filed (Month, Day, Year)	32. <b>Fe</b> gistr	rar's Signature	124	F 20.	MELI IM	7,00	-, 2		
	Regist	rar	OCT 1 7 20	006	rar's Signature	A.	28402					

			1- State of Maryland / Department of Health and Me Certificate of Death	ental Hygier Reg. N	~000 J~0~0
	Physic /Medi		Ella M. Rothamel	2. Date of Death	Day Sts. Yeer 3. Time of Death
-	Exami	ner	5. Social Security Number 6. Sex () 7. Age (In vrs. last birthday). If Under 1 Year If Under 24 Hrs.   8	B. Date of Birth (Month, Day Yea Ct. 10	Sc. County of Death  The Annual State or Foreign  Country)  9. Birthplace (State or Foreign  Country)
	Director		Usual Residence of Decedent	JCt. 10	7915 MD
	show	5	10a. State		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Country?
	23a o	aiD	532 Grays Creek Road 21122		USA
980	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show clical Examinar must be notified at	by Funerai		ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ane. than "	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Machine Operator	16b.	Kind of Business/Industry
19	filed Hygi Ither	Be Co		First, Middle, Maide	Koppers en Sumame)
ylar		To B	George Lutz Estelle		enhoffer
Mar	d 2 T is		19a. Informant's Name/Relationship (Type, Print)  William G. Rothamel (spouse)  19b. Mailing Address (Street and Number or Rural F		
	ges 1 and 2 t of Health If itam 27 or other tra				Location - City or Town, State
Baltimore,	Pa Ten ury		4 Donation 5 Other (Specify) Ballimore Cemetery 2006	6 Bal	timore, Maryland
Bai	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sta 3111 Mountain Road	d, Pasade	neral Home, P.A. ena, MD 21122
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	tin	Imil
	Examiner		(asinara artira d	seas	e
J	ned Insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
oʻ	ficate be executed physician and sthe burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
68760,	cate be ohysici the bu	edicai	d		
.O. Box 6	death certif e attending od for use as	hysician/Me	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery  Month Day Year
σ.	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	use contribute to the cause of death?
Vital Records,	The larate has	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  o 1 ☐ Yes 2 → No
Z.	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Tyes 2 No Theorem 1		6 □Other (Specify)
n of	or Attending Physician: after death. Diractor: After this certific in by the funeral director,		The state of the s	d. Describe how inju	
Division	Attending ir death. actor: After by the fune	icatio	2 Accident investigation M 1 Yes 2 No		
<u>&gt;</u>	tal or A	Certification:	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Stat	nd Number or Rural Route Number, re)
	To the Hospital or Attan within 24 hours after deat To the Funaral Director: completely filled in by the	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cause(s at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of bertifier  29c. License number	29d. Da	ate signed (Month, Day, Year)
	多知		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, 65/6	n Bornit, mD
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 2006  32. Phistrar's Signature	_/	

a Rotham

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 32829

Projection of College   2006 or Deams   Co			1- For State Certificate C	of Death	Re	g. No. 2005 3282
As Participation & Sand Street  Remining on & Sand Street  Social Secury Number   10. Secure   1		ın/	Decedent's Name (First, Middle,Last)	<del>-</del>	Month	Day Year
Remingtion & 33rd Street    Seeding Security Number   Seeding   Seeding   Seeding Number   Seeding   Seeding Number   Seeding   Seeding   Seeding Number   Seeding   Seeding Number   Seeding	edical Examii			4h City Town or Location	,	2000
A			Remington & 33rd Street	Baltimore		
The State and Number   100 College (1 for 5 m)   100 College (1 for 5					ire Min	Foreign
This issue to the country of the cou	Director	-	factorial largest	rs.	Jan 12	, 1945 Country)Kentucky
New Marine Cause   Part   New Marine Cause   New Cave Name	âuŝ	- 1		ation		10d. Inside City Limits
New Marine Cause   Production   Powro Fican   New Control   Powro Fican   Powro Fica	nd show:	-	MD Baltin	nore		1 Yes 2 No
New Marine Cause   Part   New Marine Cause   New Cave Name	farylar	탏		10f. Zip Code	10	g_Citizen of What Country?
New Marine Cause   Production   Powro Fican   New Control   Powro Fican   Powro Fica	the N			212	18	USA
Physician	h with	eral	Annual Cases N			
Physician	er dea		1 X Yes 2 No	Yes 2 X No specif	fv.	Specific white
Physician	urs aft tural"		15. Decedent's Education (Specify only highest grade completed)   16a. Deced	ent's Usual Occupation (Give	e kind of work done	
President of Disposition   Determining of Certain   Determining   Dete	72 hou n "nat	efec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NO	OT use retired)	W
Physician	outhin ene.	ם	. 3021			
Physician	filed v Hygi d oth					·
President of Disposition   Determining of Certain   Determining   Dete	212 ild be vienta narke	Ď.	-	ing Address (Street and Nu	atna Belle As	Shby ber, City or Town, State, Zip Code)
Physician	AD 2 2 shou h and 27 is					,
21 Signifier of Funeral Service   State   Anatomy   State   Anat	두 등 등 등 등		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,		20c Location - City or Town, State
21 Signifier of Funeral Service   State   Anatomy   State   Anat	MOI Pages ent of int: I		T Dullar 2 Cremation 5 Nemovaritori State	<i>-</i> ,		
Physician Medical Symmetry of the Physic	Salti ermit epartm nports jury o		21. Signation of Funeral Service Licensee Ronald S. Marector Si	Name and Address of Faciliate Anatomy	Board 655 W.	Baltimore Street
Tailure   List only one cause on each line   Between Onset and Death    Touristic   Touris		71 79	January B.	altimore, MD	21201	
The first of the contributed of the contributed of the contributed of the contribution of cont			failure\List only one cause on each line.	t the mode of dying, each do	o databas si raspiratory dire	Between Onset and
The standard of the standard o	Examiner					
Compared to the contribute of the contribute o						
Compared to the contribute of the contribute o		nine	cause. Enter Underlying Cause			
Compared to the contribute of the contribute o	ed sait	Exan				
Page 12 months?  I	execut ian and al - tra		unpended Amended			
Page 12 months?  I	760, rate be	Med				23d Date of delivery
24a. Was an autopsy performed? 1	00 00	ian/	past 12 months?		pic pregnancy	Month Day Year
24a. Was an autopsy performed? 1	30x death de atter	ysic	1 1 Ven 2 No 0 I Helenoum I	Other (Specify)		
24a. Was an autopsy performed? 1	O. Find the deby the stacked		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in		
24a. Was an autopsy findings available prior to completion of cause of death?   24b. Were autopsy findings available prior to completion of cause of death?   25b. Was case referred to medical examiner?   26b. Place of Death (Check only one)   26b. Pl	S, P.	q pe		······································		
The state of the s	ord; w requas been	plet			autops	sy prior to completion of cause of
25. Was case referred to medical examiner?  1	Rec The la	mo;				
1 Ves 2 No logo line Scene  1 Ves 2 No logo line Scene  1 Ves 2 No logo line Scene  1 Ves 2 No logo line Scene  1 Ves 2 No logo line Scene  1 Ves 2 No logo line Scene  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 No logo line Scene  28b. Time of Injury 28c. Injury at Work?  1 Ves 2 No logo line Scene  28d. Describe how injury occurred Subject shot self  28d. Describe how injury occ	tal frian:		examiner?	Othes	- Process	
The standard of the standard o	Physical directions	To	1 ✓ Yes 2 No	SIR O SON		
VS 1 of the proof	onding th r: Afte	ion:	1 Natural 5 Pending FOUND: Pay, Year) FOUND:		Subject shot	
So the first part of the first	risic Atter er dea rector	ficat	2 Accident Investigation Oct 9, 2006 1035 hrs	treet, factory, office building,	, etc. 28f. Location (S	Street and Number or Rural Route Number, City
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  (Check only one)  (Check only one)  (Check only one)  (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	Div utal or urs aft rral Di	ertii	determined (Specify) Monda under bridge			
를 들 수 할 수 이 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	e Hosp 24 ho e Fune etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc			
and manner stated	To the within To the	ledic	and manner stated			
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  October 10, 2006		Σ	zao. Signature and title of certifier		ei	
( header M, fry JR, und).			Therdor M. fix JR, un.D.	U.U.IVI.L.		
30. Name and address of person who completed gluse of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				111 Penn Street, E	Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	S	tate	24 2-4 11-4 44 41 2 44 11 2 44 11 2	and I		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fb 9860 10-17-06 vt State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

32830 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:30 AMM Marion W. Rapp October 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11110 Rokeby Ave. Garrett Park Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/09/1928 Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 💢 F 78 Months Hours 214-22-1936 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 Is marked other than "naturel", or Iteme 23a or 28a-f show treumatic event, the Medical Examinar must be notified at treumatic event, the Medical Examinar must be notified at 1 XYes 2 No MD Montgomery Garrett Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11110 Rokeby Ave. (P.O. Box 5) 20896-United States by Funeral 12. Was Oecedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No Specify: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker ould be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Wasserman Fannie Kirson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Roberts/Daughter 7 Yager Ave. Oneonta, NY 13820-Health a 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Importent: if ite
eny injury or oti Chesapeake Crematory 10-13-2006 cemetery, crematory or other place) Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Insufficiency Physician disease or condition resulting in death) 4 months /Medical Due to (or as a consequence of): Examiner 10 years Diabetes Mellitus Sequentially list conditions, Due to (u. as a consequence of). ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical ettending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes b perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: Atter this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32009 10/13/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Michael Barth 11161 New Hampshire Ave. Ste 201 Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32 Segistrar's Signature State OCT 1 7 2006 Registrar

DHMH 17 Rev 1/2001

2006

arosek

RMPP.

MARION W.

Pi known as RAY, VIRGINIA F

			1 - For Amend #20b I Registrar	er <sup>st</sup> iffi (6860 40)	20706°JI Certif	icate of Deati	h	Reg.	No.	6 32831
	Dhuoini		1. Decedent's Name (First, Middle, Las	(t)				Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Virginia	F.		Ray		- Arm		06 8,47 PM
	Examin		4a. Facility Name (If not institution, give			. City, Town, or Location	n of Death		4c. County of I	Death
			Sinai hospita	el of Baltimo	ne	Baltimore	cily			
	Funeral		5. Social Security Number 6. S		M	Under 1 Year If Under onths Days Hours	er 24 Hrs. 8. (	Date of Birth Month, Day, Ye	ar) 9.	Birthplace (State or Foreign Country)
	Director		217-40-0032	□M ¾F 64	Yrs.	55,0	0		42	MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Locati					10d. Inside City Limits
	eho	2	MD NA		ltimore					1 X Yes 2 No
	28a-f	Director	10e. Street and Number			10f. Zip Code		100	Citizen of Wha	
	with a or		2929 Edgecombe	Circle North		•	215	iog.	U.S.	•
	death with the Maryland me 23a or 28a-f ehow rinust be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S				Yes or No.	-	American Indian,
	fter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	If Ye	Decedent of Hispanic C s, specify Cuban, Mexic	an, Puerto Rica	n, etc.)		White, etc.
3	hours after ture!', or ite	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	Yes 2X No Specif	fy:		Specify:	Black
2-003p	n 72 hours after death with the Marylan "naturel", or iteme 23a or 28a-f show wifeal Examinar must be molified at	Completed	15. Decedent's Ed	fucation	16a. Decedent	's Usual Occupation		16b	. Kind of Busin	ess/Industry
<u>''</u>	within 7 ene. then "r	pje	(Specify only highest gra	College (1-4or 5+)	life. DO	d of work done during mo NOT use retired)	ost of working			
V	gien.	Ь	12th grade	2yrs	N	urse		N	ursing	Home
ana	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					rst, Middle, Maid	len Sumame)	
<u>Z</u>	Ment Ment arked arked	2	John H. Dorsey				die Be	_		
<u>a</u>	and le my	2 1	19a. Informant's Name/Relationship (	Type, Print)						te, Zip Code) 21215
≥ .	and eelth n 27		Barbara Monroe			Edgecombe				
9	ges 1 ar t of Hee if Item or othe		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □	20b. Pl   Removal from State	ace of Disposition Interpretation	on (Name of ory or other place)		OTIK	Location - Cit	y or Town, State
DE L	Pa Pa		4 □ Donation 5 □ Other (Specific	Met	ro Cre	matory In	$_{ m c}$ 10/20/	06	Baltin	more, Md
gall	permit Departin Importe any in to		21. Signature of Funeral Service Licer	500	22. Na Mar	ame and Address of Fac Ch F/H We	sility ST.			
D	907		Cala V	nauch	430	0 Wabash	Ave, B	altimo	re, Mo	21215
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter th	ne mode of dying, such a	as cardiac or res	spiratory arrest,		Approximate Interval Between
	Physician	0. 7	Immediate Cause (Final disease or condition	SEPSI	5					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ						con
	Examiner		Sequentially list conditions	ENDOC	ARDIT	15				4 days
	₽ ≈	ner	Sequentially list conditions, if any, leading to inner diate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsequ	ianoa ist):					(, )
	ocute nd trans	Examin	that initiated events	aAcut	-e Rer	ral failur	re.			4 days
Š	e exe	ŭ	resulting in death) Last	Due to (or as a consequ						11 days
08/PN	ificate be executed g physicien and as the burial-transit	edicai		a. Ne	hrolit	hiasis.				4 mays
_		Me	IF FEMALE:							
X Q	ath or ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ect	topic pregnancy			23d. Date of Month	f delivery Day Year
- -	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5 □ Ot	her (specify)			i i i i i i i i i i i i i i i i i i i	Day . oa.
Ţ.	d by detac		Part II. Other significant conditions of	ontributing to doub but not requi	ting in the under	shring course sures in Par		220 Did tobacc	na una santábu	te to the cause of death?
Š	w requires thet the death certif been signed by the attending should be detached for use a	호	Tattii. Ottor significant conditions c	onthouting to death but not resu	aling in the unique	nying cause given in Far	11.1.	1 Tes		Probably 4 Dunknown
5	w requir been si should	etec					_		20110 36	7 TODADIY 4 DOTKHOWN
ဥ	2 5 8	Completed						24a. Was an autopsy	. prio	e autopsy findings available to completion of cause of
=		ပိ						performed 1 ☐ Yes 2 🗹		Yes 22 No
vital Records,	siclen: Th certificete irector, pag	Be	25. Was case referred to medical examiner?	Magnital:		Lau	ice of Death (Cf			
0	shys this aldir	2	1 ☐ Yes 2 ☑ Mo					5 Residence		Specify)
<u></u>	ding Ph h. After th funeraí	Certification;	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Describe how in	niury occurred	
DIVISION	death death tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1 Tes 2		Lanation (Ctoo)		00
≥	or A after Direct in by	Ę	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, rarm, street, )	тастогу, опісе	201.	City or Town, Si	tate)	or Rural Route Number,
_	To the Hospital or Attending Physicien: within 24 hours siter death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	veicient To the best of multi-	wodoo do-th	aurend at the time - det	and place as 1	due to the	-(a) a= 1	
	Hos 24 hr Fun Hely	edicai	(Check only 2 Medical Exalt one)	ysician: To the best of my knownimer: On the basis of examination and manner stated.	ion and/or invest	igation, in my opinion, d	eath occurred a	t the time, date	and place, and	due to the cause(s)
	th the	Med	29b. Signature and title of certifier	and mainter states.		29c. License numbe	er	29d.	Date signed (A	fonth, Day, Year)
	o ₹ o 5	***	1	٠٠٠ ( ک			000			
	To the within To the compl	1	AD MAIAC	Doll Color		2FS -	000	1 (*)/	+cocv	10 2006
	6		ARUNAC	Xoll Ceem	22a) /T:- 5:	RES -		00	700cr	10,2006
	Twitt		30. Name and address of person who	completed cause of death (Item	23a) (Type, Prin	nt)				10, 2006
	6	ite	/ \ '	completed cause of death (Item	23a) (Type, Prir Sinai			a Himo		10, 2006

State of Maryland / Department of Health and Mental Hygiene 2005 32832 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles Reginal Rodefer Sr. 11,2006 DCT. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL HIR BEL AIR HEALTH AND BEHABILITATION GENTER HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug. 26, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**M** 2□ F Hours Director 216-16-4545 93 Yrs. Aug. Ĩ913 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other then "naturel", or items 23s or 28s-f showent, the Medical Exeminer must be notified at 1 Yes 2 24No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1405 Emmorton Road 21014 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by 3 Widowed 4 Divorced WII "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic avant space. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Worthington Rodefer Myrtle (mmn) Compton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Laura Rodefer/ Wife 1405 Emmorton Road, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial 10-16-06 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility P. A. McComas Funeral Home, P. A. Mulls 50 West Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only ene cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myochnolin ntanction Acute Seconds /Medical Due to (or as a consequence of): Examiner CONGAGUY 1n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a donsequence of): Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 No 1 Yes 27 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ۵ 1 ☐ Yes 2√2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No i Diractor: / investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral C 1.4 Certifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air North AVIAUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of M	arylan		irtment d <i>tificate</i>			iental Hy	giena Reg. No.	006	328	333
	T. Mys.		1. Decedent's Name	(First, Middle, Las	t)						2. Date of De	eath Day	Year	3. Time	of Death
	Physicia /Medic		Donald	Eugene	Roe						Octobe	,	L. 2006		a <sup>M</sup>
	Examin		4a. Facility Name (If	not institution, give	street and number,	)		4b. City, Tov	vn, or Location	on of Death	. 00000		County of Dea		
4			5 Mite	chell Dri	ive			Abino	robr			T-	larford	3	
	Funeral		5. Social Security Nu	mber 6. Se	7. A	ge (In yrs.	last birthday)	If Under 1 Y	ear If Und	der 24 Hrs.	8. Date of Bi (Month, D	rth		irthplace (State Country)	or Foreign
	Director		213-68-007	77	<b>X</b> M 2□ F	5	1 Yrs.	Months D	ays Hour	rs Min.	Aug. 1			ryland	
	p		Usual Residence of I			10 00						-		_	
	anylar show	_	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside	•
	9 Mg	Director	Maryland	Harford		Ab:	ingdon							1 1 1 1 1	s 2 <b>X</b> No
	or 2	Olre	10e. Street and Num					10f. Zip Co				10g. Citiz	en of What C	Country?	
	23a		5 Mitc	chell Dri	ve				.009			US	A		
36	d within 72 hours after death with the Maryland liene. rthen "neturel", or lleme 23a or 28a-1 ehow The Modical Exeminat must be notified at	y Funeral	11. Marital Status  1  Never Marrie		12. Was Decedent Armed Forces' 1 Tyes 2 X If Yes, Give	?		Vas Decedent Yes, specify			ecify Yes or No Rican, etc.)		<ol> <li>Race - Arr Black, Wh</li> <li>Specify:</li> </ol>	erican Indian, ite, etc.	
21215-0036	ureľ	d by	3 Widowed 4		Year or Dates:			DX						White	
5	"net	Completed	(Specif	15. Decedent's Ed ly only highest grad	ucation de completed)		(Give	lent's Usual C kind of work of	one during n	nost of work	ing	16b. Kin	id of Busines	s/Industry	
12	within ene. then "	dw	Elementary/Secon	dary (0-12)	College (1-4or	5+)		OO NOT use r	etirea)						
2	filed withi Hygiene. other then		12 17. Father's Name (F	First Middle ( 251)			Welder		10 14	othor's Nam	e (First, Middle			facture	er
JI.	d tal	Be											,		
\$	should band Ment	၉		Idward Ro			T				Jane Ha				
Maryland	O. 60 W M		19a. Informant's Nar								al Route Numb				
	s 1 and 2 if Health item 27 i			/ Mothe	r	laon F	5 Mit	chell	Drive,		gdon, 1				
0	of of or		20a. Method of Dispo		Removal from State	200. 5	Place of Dispo cemetery, cren	natory or othe	r place)	į .	Date	20c. Loc	cation - City o	r Town, State	
Ē			and the second second	5 ☐ Other (Specify		Ho	olly Hi	11 Mem	. Park	10-1	3-06	Balt:	imore.	Maryla	nd
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Fun	11/2 /, 6	nege ]		22	McComa 1317 C	ddress of Fa S Fune Okesbu	eral H urv Ro	ome, P. ad, Abi	A. Lngdor	n. Mar	vland 2	21009
			23a. Part1. Enter the shock, or heart	e disease, or comp	Moations that cause	d the deat	h. Do not ent	er the mode o	dying, such	as cardiac	or respiratory a	arrest,		Approxim Interval B	ate
1	Physician /Medical Examiner		Immediate Cause (F disease or condition resulting in death)	Final	a. Metas Due to (or as	tahi				_	Lancin		9	Onset and	
		e.	Sequentially list con-	ditions, mediate	b. Due to (or as	s a conseq									
	ted nslt	Examine	Sequentially list con- if any, leading to im- cause. Enter Underl Cause (Disease or in	tying njury											
	ificate be executed g physician and as the burial-transit	ха	that initiated events resulting in death) La	_	C. Due to (or as	s a conseq	uence of):								
68760,	siciar buri	a													
387	phy:	edical			d										-
O. Box (	The law requires that the death certifice has been signed by the attending to be a second by the attending to be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	il death 3	Ectopic pregr Other (specia				2:	3d. Date of de Month	elivery Day	Year
Δ.	that the poly of t		Part II. Other signific	cant conditions co	ontributing to death	but not res	ulting in the u	nderlying caus	e given in Pa	art I.	23e. Did	tobacco us	se contribute	to the cause of	f death?
ords,	w requires been sign should be	ted by										Yes 2□		Probably 4 [	
of Vital Records,	The law rate has be page 2 sh	Completed									24a. Was auto perf 1  Yes		24b. Were a prior to death?		s available cause of
ta		0	25. Was case referre	ed to medical					26. PI	lace of Deat	th (Check only		1016	3 2 140	
>	ysici is ce direc	To B	examiner?	Vo	Hospital:	ient 2 🗆	ER/Outpatien	t 3 DOA	04		ome 5 Res		Other (Sp	ecify)	
	nding Ph tth. r: After thi e funeral		27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending	28a. Date of Inj (Month, Da		28b. Time of Injury		Injury at Work?		28d. Describe			00.197	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director,	Certification;	3 🗌 Suicide 4 🗎 Homicide	6 Could not be determined	28e. Place of In building, e			eet, factory, of	fice		28f. Location City or To	(Street and wn, State)	l Number or F	Rural Route Nu	mber,
	To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by the	Medical (	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the besi niner: On the basis and manner s	of examina	owledge, death	occurred at the control of the contr	he time, date my opinion,	and place, death occur	and due to the red at the time.	cause(s) a , date and	and manner a place, and du	as stated. ue to the cause	(s)
	within To th	ž	29b. Signature and t	itle of certifier		^	_		cense numb				-	nth, Day, Year)	
				-	· ·	M. J	り.	-	D 45	390	)	Octo	ber	11, 200	6
3			30 Name and addre	ess of person who o	completed cause of	death (Iter	n 23a) (Type, th At	Print) wood	Roa	d #	200,6	el A	ر سريا	ND ZIN	14
30	Sta Registi		31. Date filed (Montl	n Day, Year)	7 77	trar's Signa		A				•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] [6] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 15, 2006 5:05 Margaret Mary Armstrong (Nelson) Russell October 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Yrs. Director 495-16-9187 June 24, 1919 Missouri Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rel', or Items 23a or 28e-f show Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 11834 Gova Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 √Widowed 4 □ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Balt more, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be ent of Health and Mental Is marked Margaret Mary Smith William H. Armstrong 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau once. 7551 Spring Lake Drive, Bethesda, Maryland 20817 ce of Disposition (Name of Date 21 20c. Location - City or Town, State Margaret Mary Russell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 21, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Name and Address of Facility Robert A. Pumphrey Funeral Home Chase, Inc.

23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Immediate Cause (Fi Immediate Cause (Final CAD TO PUCKOWAY **Physician** disease or condition resulting in death) /Medical Examiner MOCHOM 5-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nding physician and a that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner eath Certification: After Injury 5 Pending 1 atural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier a ROTELW MOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10720 8600

Registrar

State

31. Date filed (Month, Day, Year) 0CT 1 7 2006

32. Registrar's Signature

Rockville

Amend item#5, perFH, 0860, 10/27/06 TT Certificate of Death

1. Decedent's Name (First, Middle, Last)

6004 Loganwood Drive

4a. Facility Name (If not institution, give street and number)

Simon Peter Rosen

**Physician** 

/Medical

Examiner

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F 73 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiane. 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at Maryland Montgomery Rockville Direct 10e. Street and Number 10f. Zio Code 6004 Loganwood Drive 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physicist 17. Father's Name (First, Middle, Last) Louis Rosen Ann Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau Adrienne Rosen / Wife 6004 Loganwood Drive, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. October 16 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2006 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and A The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by tha a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Completed cartificate has b lirector, page 2 sl funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 9 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA th: 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After Injury s after de. 1 XNatural 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funerei C 1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number D45880

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 7 2006

32. Registrar's Signature

Leon Hwang, MD 31. Date filed (Month, Day, Year) State of Maryland / Department of Health and Mental Hygien (1) 2. Date of Death Month October 13, 2006 3:40 РМ 4c. County of Death 4b. City, Town, or Location of Death Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) August 4, 1933 England 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryhand 20814 7557 Wisconsin Avenue Approximate Interval Between Onset and Death 3 Years 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 🖾 No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

October 16, 2006

State

1396 Piccard Drive, Rockville, Maryland 20850

State of Maryland / Department of Health and Mental Hygiene 0 6 32836 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ross OCTOBER 1925 LIZABETH 2006 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHNS HOPKING N/A HUSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/30/1956 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 113-50-4597 49 Yrs NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at 1 No 2 No N/ACHERRY HILL Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1297 BUNKER HILL DRIVE 08003 USA death . Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 "neturel", or WHITE 1 ☐ Yes 2 🕅 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR - SPORTS TALL PINES CAMP lith and Mentel Hygier 27 te marked other ti r treumatic event, th permit. Pages 1 end 2 should be file Department of Heelth and Mentel by Important: If Item 27 te marked oth ery lipiury or other treumatic event SDRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT HINDEN EILEEN JUDWIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN HINDEN / BROTHER 25 HORSESHOE RIDGE ROAD - SANDY HOOK, CT 06482 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State MT. ARARAT CEMETERY 10/15/2006 FARMINGDALE, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LEUKEMIA LYMPHOGSTIC (HRONIC 6 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 QNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural 5 Pending deeth. 1 Yes 2 No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 / Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 12, 2006 MD D0062144 Name and address of person who completed cause of death (Item 23a) (Type, Print) GOD MWOIFE ST Baltimore, Maryland 21287 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			1 - For Amend item#19a,po	State of Mar erFH, G860,	yland / Depa 10/17/06 <b>J</b> T/	ortment of F Stificate of	lealth and M <i>Death</i>	lental Hyg R	iene <sub>eg.</sub> 2006	32837			
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  STANLEY			RUBE	NSTEIN	2. Date of Deat Month OCTOBE	Day Yea	3. Time of Death 5:40 P M			
	Examir		4a. Facility Name (If not institution, give st. HOSPICE OF BALTIMOR	The state of the s	ST CTD	4b. City, Town, o	r Location of Death TOWSON		4c. County of De				
	Funeral		5. Social Security Number 6. Sex	7. Age (i	In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 03/03/1	9 F	LTIMORE  irithplace (State or Foreign Country)  N.Y.			
ŀ	Director		Usual Residence of Decedent										
	Aarylar f show ed at	ō	MD BALTIMO		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	h the h or 28a-	irect	10e. Street and Number		DALI	10f. Zip Code		1	0g. Citizen of What				
	ath wit s 23a c	Funeral Director	6620 SANZO ROAD			21209			U.S.A				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Fune	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Xes, Give Year or Dates:	WII	Ves Decedent of H f Yes, specify Cub: I ☐ Yes 2 1 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	nericen Indian, nite, etc. HITE			
15-0	n 72 h ''natu edical	etec	15. Decedent's Educa (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of work	ing	16b. Kind of Busines	s/Industry			
212	d withi giene. er than the M	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ACTURER			WOMENS (	CLOTHING			
Maryland	ould be file Mental Hy arked oth	To Be (	17. Father's Name ( <i>First, Middle, Last</i> ) DAVID	RU	JBENSTEIN		18. Mother's Name		,	NKELSTEIN			
Mary	12 should h and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type RUBERTA RUBINSTEIN	e. Print)	ı				, City or Town, State	, Zip Code)			
ē,	ages 1 and 2. It of Health ar It item 27 is or other train	3	ROBERTA RUBINSTEIN  20a. Method of Disposition		20b. Place of Dispos		OAD - BAL		MD 21209 20c. Location - City	or Town, State			
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation ☐ Other (Specify)	moval from State	CARROLL C	REMATION	10/16		HAMPSTEAD				
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature Fundame Licenses		89	Name and Addre	ss of Facility SOL	LEVINSO	ON & BROS. IKESVILLE	, INC. , MD 21208			
l	17		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between Onset and Death			
	Physician /Medical		Immediat - Cause (Final disease condition resulting in death) a.	Due to (or as a c	on hay	c 5+	VKE			weeks			
P	Examiner		Sequentially list conditions b.	Due to (or as a c	onsequence on								
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):								
o,	icate be executed physician and s the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):								
68760,	cate be physici the bu	edical	d.										
P.O. Box 6	ath certif ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	□Fetal death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year			
	uires that the de signed by the a	by Ph	Part II. Other significant conditions contr	ibuting to death but n	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?			
ord	w require been sig should b							1 🗆 Ye	es 🎾 No 3 🗆	Probably 4 Unknown			
al Records,	or Attending Physician: The law after death. Director: After this certificate has b in by the funeral director, page 2 st	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ged? death'	autopsy findings available completion of cause of			
Vital	ysicial is certif directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 100 Ho	spital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3 DOA Oth	26. Place of Death er: 4 □ Nursing Ho	n <i>(Check only one</i> me 5 ☐ Reside		pocific (a N.S. Oc. 10			
Division or	ing Ph After thi uneral	on: T	27. Manner of Peath  125 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	28b. Time of Injury	28c. Injur Worl	y at k?		w injury occurred	ecity) vaspaq			
/isio	l or Attend after death. Director: /	ficati	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury	- At home, farm, stre		Yes 2 □ No	28f. Location (Str	reet and Number or	Rural Route Number,			
		Certification:	4 Homicide determined	building, etc. (	Specify)			City or Town	, State)	, and the state of			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one) 1 Sertifying Physic 2 Medical Examine	clan: To the best of n er: On the basis of ex and manner stated	amination and/or inv	estigation, in my o	pinion, death occurr	and due to the cared at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)			
)	To t To t	Σ	29b. Signature and title of certifier	lus		29c. Licenso	8303	29	Od. Date signed (Mod	nth, Day, Year) 4 2006			
(	8		30. Name and address of person who com		(Item 23a) (Type, F	Print)		imre	21 cm				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		9 -	- 50 1/1						
	Registr	ar	OCT 1 7 200	b Alegran	13. A	BALL I							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32838 State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 0013 AM SPRATLEY 2006 VTOBEK 4a. Facility Name (If hot institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE ARBOR NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min. Days Months Hours 1 M 2 □ F 212.58.6293 Usual Residence of Decedent MD. 55 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 FYes 2 No NA BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code STREET PAYSON 21217 1814 N. U8A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CARPENTER 1214 GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JERLEAN SPRATLEY CORREL GOODMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S1., JERLEAN NEAL MOTHER) 1814 N. PAVSON BALTIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lostion - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10.17.06 BALTO. MD LOUDON PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service License Vangon 5151 BALTO, NATE PIKE, BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY 710 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): DAGULOPA resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 1 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death

Jet, Mc.
Jermit. Pages 1 and 2 shc.
Department of Health and M.
Importent: If Item 27 1any njury or ~." **Physician** /Medical Examiner 102 The law requires that the death certificate be executed Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

al Hygiene.

Mental

be filed within 72 hours after

altimore, Maryland 21215-0036

by Funeral Director

Completed

Examiner physician and s the burial-transit Physician/Medical attending physic for use as the b certificete has been signed by the a rector, page 2 should be detached it Be Completed by After this certific funeral director, Certification: To death.

P.O. I

vision of Vital Records,

Attending Physician:

ò Hospital

fo the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

5 Pending investigation 6 Could not be determined 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifie (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

October 12,

301 SOUTH HANDLY 31. Date filed (Month, Day, Year)

OCT 1 7 2006



3

State

Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 6:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD tal ANE If Under 24 Hrs. 7. Age (In yrs, last birthday)
Yrs. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth **Funeral** 9398 Days 339-10 - 9392 Usual Residence of Decedent 1 □ M 2 7 F, lorth (arolli Director permit. Peges 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumalte event, if a Marileal Examinat mail be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director HARFURD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Blac 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SERVICE HUSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 ENJAMIN JENTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 19a. Informant's Name/Relationship (Type, Print) LOGEWOOD -ane HILOA 20b. Place of Disposition (Name of cometery crematory or other, place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06 5 Other (Specify) 4 Donation SERVICES DelAL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility NEWPORT Chapel FOREST Hill, MD 21050 & CREMATION SERVICES Approximate Interval Between Onset and Death 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner House. The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the attending i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes detached 9 Unknown 9 Unknow à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2000 2 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 2 🗌 No 1 Tes Director; 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined atter 4 | Homicide within 24 hours a To the Funerei [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LULI nuo who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

DHMH 17 Rev 1/2001

State

Altill

3445 E

32. Registrar's Signature

BUY

haires

			State of Maryland / De State of Maryland / De	partment of Health and Mertificate of Death	lental Hygiene	2006 32840
	*		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physici: /Medic		IDESSA IDA ST	EWART		2,2006 9:10 AM
1	Examin	51	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
· ·			LEVINDALE	BALTIMURE  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMORECITY
*	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country)  MARULAND
М.			Usual Residence of Decedent		0411250,17	7
	inylan show	_	10a. State 10b. County 10c. City, Town or		$\alpha$	10d. Inside City Limits
	8a-f (	ecto	MARYLAND N/A	BALTIMO		Zen of What Country?
	a or 2	ā	10e. Street and Number	10f. Zip Code	d log. Cily.	Zen of What Country?
	na 23	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Spo		14. Race - American Indian,
9	after or ital	Fun	Armed Forces?  1 Never Married 2 Married 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:		Black, White, etc.
21215-0036	72 hours after death with the Maryland Inatural, or Itema 23e or 28e-f show dical Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: BLACK
5	"nati	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation (UN KNOS) ive kind of work done during most of work a. DO NOT use retired)	ار لارد ing	ind of Business/Industry
7	within tene. then	E C	Elementary/Secondary (0-12)  College (1-4or 5+)	. 55 115 1 335 15.1155)	FI	IRNITURE STORE
	I Hygi other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden	
<u>Jar</u>	Mental Mental arked c	To B	MATTHEW ROG	ERS PRISC	CILLA	ROSS
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens in the Comparative of the Asia marked other than "natural", or tlama 23a or 28a-f show mortant: If item 27 is marked other than "natural", or tlama 23a or 28a-f show any liquity or other traumatic event. Its Madical Examinat must be notified at once.			ailing Address (Street and Number or Rura		
	of Health of Health litem 27			MATHEW ST	Vate 200 Lo	MD. 21218 pocation - City or Town, State
altimore,	Pages nent of H int: if its iry or of	3		rematory or other place)		
ij	permit. Pag Department Important: I any injury c		4 □Donation 5 □Other (Specify) □ TARRIS  21. Signature of Funeral Service Licensee	SON FOREST 10 - 3	10-06 OU	SULTANI HOME
Ba	permit. Departr importa any inj		Dietich N. William	22. Name and Address of Facility RO	AVE BAI	TTHORE, MD, 2/2/7
14			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between
	Physician	8	Immediate Cause (Final disease or condition	ARTERY DIS	EASE	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
g	Examiner	_	Sequentially list conditions, b.			
	ted nsit	nlne	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	execu n and ai-Ira	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			-
8760,	law requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit		d.			
89	ntiffica ng ph	Physician/Medical	IF FEMALE:		- 1	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant  in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	2	23d. Date of delivery  Month Day Year
P.O.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		,
م	that the de led by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Division of Vital Records,	w requires that s been signed k stould be deta	Completed by	RENAL FAILURE		1 ☐ Yes 2	□ No 3 Probably 4 □Unknown
00	aw rec as bee 2 shor	olete	ANDXIC BRAIN INJURY		24a. Was an	24b. Were autopsy findings available
R	The lav	mo:			autopsy performed? 1 ☐ Yes 2 ☑ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ita	san: artifica ctor, p	Bec	25. Was case referred to medical examiner?		h (Check only one)	
× ×	Physician: r this certifica ral director, I	ပ္	1 ☐ Yes 2 XNo Hospital: 1 X Inpatient 2 ☐ ER/Outpa		ome 5 Residence	
Ĕ	ing P	<u>o</u>	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Tim Infur		28d. Describe how infur	y occurred
isi	Attending ir death. ector: After by the fune	llcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street and	nd Number or Rural Route Number,
Ξ	after after I Dire	Certification:	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, State	1)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place,	and due to the cause(s)	and manner as stated.
	the Hin 24 the Fi	ledical	one) and manner stated.			
	To t To 1	Σ	29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
	N		tenm 11. www.sting	10063327	10	112/2006
	m	1 22	30. Name and address of person who completed cause of death (frem 23a) (Tyles GIZAW WOLDEHIWOT 2434 WES		UE BAIT	IMODE MIN DIDIE
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	" Ma	04, 13/10/1	MILLE, MIJ WINIS
	Registi		31. Date filed (Month, Day, Year)  OCT 1 7 2006  32. Registrar's Signature	SALL!		

06-07360

Please Type or Print in Black Indelible Ink UNK UNK State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1524 hrs Medical Examiner Shyree Strayer September 30, 2006 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Deat 4c. County of Death 3119 East Baltimore Street Baltimore 9. Birthplace (State ounk 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Foreign Country) Months Days Hours Min Director Oct 25, 1967 38 Usual Residence of Decedent unk | 10d Inside City Limits 10a. State unk 10b. County unk 10c. City, Town or Location ì Yes 2 No 28a-f show hours after death with the Maryland rector 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country' 72 USA or items 23a 12. Was Decedent Ever in Unink 11 Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black Armed Forces? White, etc. 1 Never Married 2 Married Yes Yes 2 X No specify: Widowed 4 Divorced f Yes. Give Year white \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done in k 16b. Kind of Business/Industry unk during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and 2 should be filed within 72 l lealth and Mental Hygiene item 27 is marked other than "r umatic event, the Medical Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jre, .
Pages I and 2 ant of Health an. . 111 Penn Street Baltimore, MD O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State portant: 4 Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy
Baltimore, MD re of Funeral Service Licensee
Rouald S. Wade Board 2<u>1201</u> 655 W. Baltimore Street 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Death failule, List only one cause on each line /Medical Acute subarchnoid hemorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Rupture of a berry aneurysm Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last cal X UNPENDED AMENDED item#23a-b, 27, perME,g860, 10/18/06 TT Physician/Medi Division of Vital Records, P.O. Box 68760, ling phys as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Hospital 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 1, 2006 person who completed cause of death (Item 23a) Susan Hogan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 006 32842 For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:27 PM Thomasine J. Springham OCTOBER 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAL HOSPITAL BALTIMORE N/A 8. Date of Birth (Month, Day, Year) 10/24/1933 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**∑**F 216-28-1699 72 Yrs. Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Modical Examinar must be contilled at 1 ☐ Yes 2 No MD Columbia Howard Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10310 Swift Stream Place Apt. 203 21044 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 5+ Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Margaret Mulvihill 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 shr Depertment of Heelth and Important: if I tem 27 is ma eny injury or other trauma once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Cherrydell Road, Catonsville, Maryland 21228 Russell Springham (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Bayview Crematory | 10/16/2006 Baltimore, Maryland Docation 5 Other (Specify) 21 Sign ture of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** 30 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cele hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 110 25. Was case referred to medical examiner?

1 Tes 2 No Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours efter death.
To the Funerei Director: Afte completely filled in by the fun 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Setur N. Cho, MD Surgeon D41129 OCTOBER 13. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARY LAND W. CHO, M.D. SINAI HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 7 2006 Registrar

SPRINGHAM

		1. Decedent's Name				ertificat	e of E	Death	2. Da	te of Death	No.	3. Time of Death
Physic /Med	ical	MARGAR  4a. Facility Name (If	ET ANN		ES	4b City	Town or	Location of	/	10 0		06 7.30 AM
Exam	iner	MERCY	MEDICAL	L CENTE		1.	3ALT	MOR	E CIT;	ý		
Funera Directo		5. Social Security Nu 215-09-65	5 <b>99</b>		9 (In yrs. last birthd Yrs	Months		Hours	Min. (Mo	te of Birth onth, Day, Yea ust 31	ar)	Birthplace (State or Foreign Country) Maryland
ryland how		Usual Residence of 10a. State	10b. County		10c. City, Town or							10d. Inside City Limits
the Ma	Director	MD 10e. Street and Num	Baltimo	ore	Timon	10f. Zip	Code			100	Citizen of What	1 □ Yes 2 No
h with	ai Di		Oulaney Va	lley Rd.	M205	101.2.	2109	<del>)</del> 3		US		Country.
NOTE, MATYIANG ZIZID-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Madical Examinar must be inclined at	d by Funerai	11. Marital Status  1 Never Marrie  3 Widowed	ed 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 I If Yes, Give Year or Dates:		3. Was Deced If Yes, spec	offy Cubar	spanic Origi n, Mexican, Specify:	in? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - A Black, W Specify: W	
INIAL YIGHTIQ Z.I.Z.I.D-UUDOU d.2 should be filed within 72 hours aft th and Mental Hygiene. 77 ie merked other than "natural", or traumatic event, ile Medical Expiri	Completed		15. Decedent's Educ fy only highest grade idary (0-12)		+) (G	ive kind of wo	rk done di se retired)	uring most (	of working	16b.	Kind of Busine	-
A filed al Hygid tother	Be Co	17. Father's Name (			Date	S ASSU	Clate	18. Mother	's Name (First,	_	en Sumame)	<u> </u>
should be in marked of umatic eve	70		B. Behr	na Print)	19b M	ailing Address	(Street 2		neresa	Loch	ner v or Town, State	o. Zin Cadal
Te, Ma 1 and 2 s Health an tem 27 te		Eileen		: - Daughi		•					n, PA 1	, , , ,
Dattinore, permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.			osition  Cremation 3 R  Dther (Specify)	emoval from State	20b. Place of Dicemetery, of Parkwoo	d Ceme	ther place tery	10	Date <b>D/11/06</b>	Par	Location - City	, MD
Dermit Depart Import			ieral Service License Lam. G. Dau		DVR	22. Name ar	ork F	s of Facility	Ruck Towson,	owson :	Funeral 204	Home, Inc.
		shock, or hear	e disease, or compli t failure. List only on	e cause on each lin	the death. Do not ne.	enter the mod	le of dying	, such as ca	ardiac or respi			Approximate Interval Between Onset and Death
Physician //Medical		Immediate Cause (I disease or condition resulting in death)			OVASCUL a consequence of):		CLL	APSE	<u> </u>			
Examiner		Sequentially list con	ditions h		MINAL a consequence of):	SEPS	515					300
cuted od ransit	Examiner	if any, leading to imicause. Enter Under Cause (Disease or i that initiated events	C C		a consequence on,							
icate be executed physician and the burial-transit		resulting in death) L	ast	Due to (or as	a consequence of):							4
oo/ rifficate ng phys as the	Aedicai	LIE ESTATE	- 0									
The Cold us, T.C. DOX 00100,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp				_	23d. Date of Month	delivery Day Year
S, T.	þ	Part II. Other signifi	cant conditions con	tributing to death be	ut not resulting in th	e underlying o	ause give	n in Part I.	23			e to the cause of death?
w requir	leted					<del></del>			24	1 ☐ Yes a. Was an		Probably 4 Unknown
The lavecate has	Completed									autopsy performed Yes 2	death	autopsy findings available to completion of cause of ?? 'es 2 \(\sum \text{No}\)
villa rsiclan s certifi director	To Be	25. Was case referr examiner?	·	ospital:	nt 2□ ER/Outpa	tient 3 DC	Othe		of Death (Chec		6 □Other (S	*naciful
To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be d		27. Manner of Death  1 Natural  2 Accident	·	28a. Date of Injur (Month, Day			Bc. Injury Work	at ? es 2 □ Ne	28d. De	escribe how in	jury occurred	рөспу)
UIVISION Attentes atter death in Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory	/, office			cation (Street y or Town, St		Rural Route Number,
To the Hospital or within 24 hours after to the Funeral Direction of th	Medical	29a. Certifier (Check only one)	Certifying Phys	sician: To the best of ner: On the basis of and manner sta	examination and/o	eath occurred r investigation	at the time , in my op	e, date and inion, death	place, and due occurred at th	e to the cause se time, date a	(s) and manner and place, and c	as stated. due to the cause(s)
To the H within 24 to the Fi complete	Me	29b. Signature and	itte of centiller			290	c. License	number		29d. I	Date signed (Mo	onth, Day, Year)
0,0		pl.			n (I)		123			10	20/2/06	
(	/		iss of person who co CHESLER	MD	eath (Item 23a) (Ty 22 S	oe, Print) GRED	NE	STREE	ET BA	LTIMER	E, MD.	2/20/
S Regis	ate	31. Date filed (Mont	2. Qay. Year)6	32. Registra	ar's Signature	S. P. Sand						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 32844 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sathirabarabangse

4b. City, Town, or Location of Death 8.48nw 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore 8800 Ridge Di talcon handal Stown Date of Birth (Month, Day, Year) L.J. : 30: 1928 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Months Hours 1 □ M 2 7 F Thailand Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ridge Dr. 2113 8800 hailanu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 □ Divorced Ihai 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Donustic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State Chanya Nilanant Daughki 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Cremosery 10/16/06 Baltimore. 22. Name and Address of Facility Volument Circle funerou Service 21. Signature of Funeral Service Licenses Randollistern 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Jeath tmmediate Cause (Final Res days disease or condition resulting in death) Due to (or as a consequence of

Pnysician /Medical Examiner

attending physicien and for use as the burial-transit

signed by the a

To the Hospital or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours after death To the Funerel Director: completely filled in by the filled in by the

Division of Vital Records,

P.O. Box 68760.

Examiner

Physician/Medical

à

Completed

2

Certification:

Medical

**Physician** 

/Medical

Examiner

10a State

Director

Completed by Funeral

Be ၉

**Funeral** 

Director

Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause (Disease or injury) that initiated events resulting in death) Last

Nage Due to (or as a consequence of) it. D

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

3 Ectopic pregnancy

23d. Date of delivery Month Day

4□Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 1 Yes 2 XNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

25. Was case referred to medical examiner? 1 Yes 2X No

Mark

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 🗌 Suicide

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

NONE М 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kahle

Pochna C. 31. Date filed (Month, Day, Year)

Towson, MD 21204

State Registrar

732. Registrar's Signature Darles OCT 1 7 2006

		For State Registrar	State of Marylar		artment of Health rtificate of Deatl	7 Re	g. No. UUD 32845
Physic /Medi		1. Decedent's Name (First, Middle, La  Bettie	L. Shaf	fer		2. Date of Death Month Chuber	Day Year 3. Time of Death 03: JJAM
Examir	ner	4a. Eacility Name (If not institution, give Sinai Hospi fa. 5. Social Security Number 6. 5	l of balk's		4b. City, Town, or Location Salfino If Under 1 Year If Under	of Death  Let G Hy  or 24 Hrs. 8. Date of Birth	4c. County of Death  n/a  Rightnage (State or Foreign
Funeral Director			1□ M 2\\ 75	Yrs.	Months Days Hours		
with the Maryland a or 28a-f ehow	ctor	10a. State 10b. County  Maryland n/a		y, Town or L Saltimo	ocation ore City		10d. Inside City Limits 1 💆 Yes 2 🗆 No
ier death Iteme 23	Completed by Funeral Director	10e. Street and Number  2211 W. Rogers A  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Novorced	12. Was Decedent Ever in U Armed Forces? 1 _ Yes 2 M No If Yes, Give Y Year or Dates:		10f. Zip Code  21209  Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic  1 ☐ Yes 2 ☑ No Specify	Origin? (Specify Yes or No- an, Puerto Rican, etc.)	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White
2121 ad wifhin or then "	Complete	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ade completed)  College (1-4or 5+)  n/a	(Give	edent's Usual Occupation s kind of work done during mo DO NOT use retired)	ost of working	Black & Decker
Maryland 2 nd 2 should be filed the and Mental High the marked other traumatic event.	To Be	17. Father's Name (First, Middle, Last William Ro  19a. Informant's Name/Relationship (	yden Long		Ma	her's Name (First, Middle, Namian L. ber or Rural Route Number,	Carney  City or Town, State, Zip Code)
or Hear of Hea		David D. Downes/ 20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3  ↑ □ Donation 5 □ Other (Speci	20b. I	Place of Disp cemetery, cre	Box 5516, To osition (Name of unatory or other place)	10/19/06	nd 21285-5516 Oc. Location - City or Town, State  Cockeysville, Maryla:
Baltimo permit. Pag Department important: i		21. Signature of Funeral Service Lice	- Contract of the Contract of	)   2 I	2 Name and Address of Fac	Home of Dula	aney Valley Inc.
Physician // Medical Examiner // Spring of the pring-transit of pring-transit // Physician and Physician and Phys		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b.  Due to (or as a consect  C.  Due to (or as a consect  Due to (or as a consect  d.	quence of):	raaxial fen	MIDA POSEDATE A PICE	natura 2/12 d
Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires thet the death certificate rideath. •ctor: After this certificate has been signed by the attanding phy by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)	Mills.	23d. Date of delivery Month Day Year
rds, P.	٥	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause given in Par		accoluse contribute to the cause of death?
al Record: The law requir cate has been si	Completed					24a. Was ar autops perform 1 ☐ Yes 2	prior to completion of cause of
Division of Vital Records, P.O. Box ior attending Physician: The law requires thef the death cert after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	on: To Be	25. Was case referred to medical examiner?  150 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Ho spital: 1 patient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	ent 3 DOA Other: 4 1	Nursing Home 5 Reside	nce 6 Other (Specify)
Division ttel or Attendi rs aftar death. al Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of Injury - At h building, etc. (Speci	West.	ing Facility	28f. Location (Str City or Town 22/1 Wes	eet and Number or Rural Route Number (1 State) The WCS
DIVISIO  To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A	Medical	29a. Certifier (Check only one)  2□ Medical Exa  29b. Signature and title of certifier	hysician: To the best of my kniminer: On the basis of examiniand manner stated.	owledge, dea ation and/or i	th recurred at the time, date nvestigation, in my opinion, d	eath occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)  Id. Date signed (Month, Day, Year)  Wester 15, 2006
5		30. Name and address of person who Adrian Barbul, M.	D. 2401 W.	Belve	dere Ave., Ba		
St Regist	tate trar	31. Date filed (Month, Day, Year)	32. Régistrar's Sign	ature	Contis		

9		For State Registrar	State	of Marylan		artment of H		Mental Hy	giene Reg. 200	6 32846
Physi	aion	1. Decedent's Name (First, Middle	e, Last)					2. Date of D		3. Time of Death Year
Physi /Med		Richard Burt So						Oct.	16 200	06 6:45 A M
Exam	iner	4a. Facility Name (If not institution					or Location of Dea	th	4c. County o	
	36 J. M.	Oak Crest Rena: 5. Social Security Number	Lssance G	7. Age (In yrs.	last birthday)		ville If Under 24 Hrs	s. 8. Date of Bi	Balti	
Funera Directo		280-18-6636	1□M 2□F X	91	Vec	Months Days	Hours Min	. (Month, O	ay, Year) 28 1915	Birthplace (State or Foreign Country)     Ohio
P.		Usual Residence of Decedent  10a. State 10b. County		10a Cia	y, Town or Lo	antion .				
ME CIVILTH 4 183/28/15 death with the Maryland me 23e or 28e-1 ehow	ō									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
CORULT 1645 A SINGLE OF THE CORULT OF THE CORULT OF THE MANY AND OF THE CORULT OF THE	Director	MD Baltin	nore	Pa	irkvill	10f. Zip Code			10g. Citizen of W	Λ
22 miles		8820 Walther B	byd			2123	4		USA	
Geath death	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decedent of H	Hispanic Origin? (	Specify Yes or N	o- 14. Race	- American Indian,
# # # # # # # # # # # # # # # # # # #	F	1 Never Married 2 Mar	ned 1 ☐ Yes If Yes, G	2 💢 No		1 ⊡ Yes 2 ∏ No		no nican, etc.)		white, etc. white
5-0036 72 hours after natural; or to	d by	3 X Widowed 4 □ Divorced	Year or f	Dates:		**				
15-	Completed	(Specify only highe	t's Education st grade completed,		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bus	siness/industry
of filed within all Hygiene.	E	Elementary/Secondary (0-12)		(1-4or 5+) 2	Eng	ineer	,		Black &	Decker
at Hygie	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	e, Maiden Sumame	
Marylance 2 should be 1 and Mental 1 le marked or aumatic eve	To E	Rfichard Schul	ze				Ne1	1 Burt		
		19a. Informant's Name/Relations							per, City or Town, S	
ore, M		Jeffrey L. Schi	ılze/son	20b F	A STATE OF THE PARTY OF THE PAR	Shaffer sition (Name of	Dr., Ne	Date Date	om, PA 17	349 Dity or Town, State
AIC Martinore, mit. Pages 1 ar partment of Heap portant: If tiem y Injury or othe		1∑ Burial 2 ☐ Cremation		State C	emetery, crer	natory or other pla	10/1	.9/06		
Baltimo Bartimo Department Important: I	اند	4 □ Donation 5 □ Other (S 21. Signature of Eugeral Service		Du]		alley Me		ardens	Timonium	, MD
B egg				Flagle				e of D	ulaney Va	11ey, Inc. 093
	(1) A (1)	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	Pado er the mode of dyi	<b>n1a Kd.,</b> ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between
Physician	n	Immediate Cause (Final disease or condition				c Dis	Or. 6 6			Onset and Death
/Medica	ıt 💮	resulting in death)		(or as a conseq		1 12 1 21	0,90			
Examine		Sequentially list conditions,	b	OBSONO LICATOR						
be desir	Examiner	il any, laconing to immediate cause. Enter Underlying Cause (Disease or injury	Dusto	(ur as a conseq	liance of):					
60, be executed iclen and burial-transil	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):					
3760, ate be executed sysicien and he burial-transit	cai E		d							
687 tiflicate g phy as the			- U.							
vision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be er cleath.  sctor: Atter this certificate has been signed by the attending physicien by the funeral director, page 2 should be detached for use as the burit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Peta		Ectopic pregnanc	v			of delivery
O. B e deal he att	Sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify) _	,		Mon	th Day Year
P.O. hat the de de by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderking cause on	en in Part I	23a Did	tobacco use contri	bute to the cause of death?
Division of Vital Records, to Attending Physicien: The law requires tatler death.  Director: After this certificate has been signe in by the funeral director, page 2 should be cin by the funeral director, page 2 should be	d by	Tarrii. Other signment condu	one contributing to t	douth but not 183	aking in the u	ndariying cadaa gi	rentin i ditti.			3 ☐ Probably 4 ☑Unknown
cord * requir been s	Completed							24a. Wa	24h W	fore autoney findings available
II Re The lav	E G							auto perf	ormed? d	fere autopsy findings available for to completion of cause of eath?
Vital Ician: T certificat	Be Co	25. Was case referred to medica	1				26. Place of De	1 ☐ Yes		□Yes 2□No
on of Vita ding Physician: h. After this certific funeral director,		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Ott			idence 6 Othe	r (Specify)
on of ding Ph J. After th funeral	.:.	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date (Mor	of Injury nth, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurre	d
Sio Itendi Jeath. Tor: A	catl	2 Accident investi	gation		<u> </u>		Yes 2□No	00( )	(O)	
	Certification: To	4 Homicide determ	pined 280. Plac	ding, etc. (Specif	ome, rarm, str fy)	eet, factory, office		City or To	(Street and Numbe own, State)	r or Rural Route Number,
DIVISIO Prospital or Attendi 24 hours after death.  Funeral Director: A etely filled in by the fu	S C	29a. Certifier 1 Certifyii	ng Physician: To th	ne best of my kno	wledge, deatl	n occurred at the ti	me, date and plac	e, and due to the	cause(s) and man	ner as stated.
Di To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, in my	opinion, death occ	curred at the time	, date and place, a	nd due to the cause(s)
To the I for the Complet	Σ	29b. Signature and title of certifie	r			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		I am or	rome			05	8646		Octobs	- 16 2000
B .		30. Name and address of person				Print)		0 1		
	State	31. Date filed (Month, Day, Year,	% % CO	Redistrar's Signa	tho:	1300 F	10 ro	Taiku	116 001	1) 21734
Regis			7 2006		M. A.	Cartes				

State of Maryland / Department of Health and Mental Hygien 2006 32847 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 133 AM Sarah Mariana Sadaka OCTOBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EDICAL DENTER HNNE BALTIMOLE WASHINGTON BURNIE GLEN HRUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08-19-1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. 214-40-7297 83 Director Aruba Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other than "natural", or Items 23e or 28a-f ehow traumatic event, the Madical Examinar must be motified at 1 ☐ Yes 2 🖾 No Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7926 East Park Drive 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miguel Mansur unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 if item 27 Mrs. Carla Gernert / daughter 151 Ryan Road; Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park | 10-18-2006 Glen Burnie, MD 21. Sonature of Funeral Tenfic 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sivera cu co /Medical Due to (or as a consequence of) **Examiner** 5008 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed been signed by the attending physicien and should be deteched for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an certificete 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral efter death. I Director: After th 28a. te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural Injury 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours el To the Funeral D completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 510~ BALDIMONE WASNINGOON MUDICAL Conom 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

SARAH

SABAKA

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Marylar		tificate of		R	eg. N. (	006	32848
Phys /Me	ician dical		JORA .	Spf	NGLO	n	2. Date of Dea Month		Year OG	3. Time of Death (1/30) M
Exan		4a. Facility Name (If not institution, g	· ·			r Location of Death		1	unty of Dea	
Funer	a1	Anne Arundel Med 5. Social Security Number 6		. last birthday)	Annapo1	If Under 24 Hrs.	8. Date of Birth		ne Art	inde1 hplace (State or Foreign buntry)
Directo		213-36-0587	1□M 2 <b>\$</b> 68	Yrs.	Months Days	Hours Min.	(Month, Day 05-09-		Co	MD
rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	cation					10d. Inside City Limits
e Mary a-f sh	ţ	MD Anne	Arunde1	G1en	Burnie					1 ∐Yes 2 Mino
vith the	Funeral Director	10e. Street and Number			10f. Zip Code	•	1		of What Co	ountry?
eath v ns 23a must	20	1108 Nottingham	Drive 12. Was Decedent Ever in U	J.S. 13. V	2106 Vas Decedent of H		ecify Yes or No-		S.A. Race - Ame	rican Indian,
ING 21215-U036  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	<u>چ</u>	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		Yes, specify Cuba	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rićan, etc.)	Sp	Black, Whit ec <i>ify:</i>	e, etc. white
15-0	a ta	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced	ent's Usual Occup	eation during most of work d)	ing	16b. Kind	of Business	Industry
d 21215- filed within 72 Hygiene. wher than "na ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	1)		Ov	n Hom	ie
be filed tral Hyg d other	Re C	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, I	Maiden Su	rname)	
	1	James Saunders		10, 11, 11			ura Moor			
Maryla Id 2 should Ith and Mei It is marke		19a. Informant's Name/Relationship Mr. Gene S. Span			•	and Number or Run gham Drive				
Hear Hear		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place	ce)				Town, State
Pages ment of l ant: If its		1 ☑ Bunal 2 ☐ Cremation 3 4 ☑ onation 3 ☐ Other (Sp	nemovar from State	en Haver	n Mem. Pa	ark 10-1	17-2006	G1er	Burn	ie, MD
Baltimore, permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other	once.	21. Signature of Hineral Cervice Lic	M0131	A 22	Name and Addre	ss of Facility Sin	ngleton	Funer	al Ho	me, PA
		23a. Part1. Enter the disease, or co	mplications that caused the dea						ш 210	Approximate
Physicia /Medica		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.  a.  Due to (or as a conse	Sta	ye i	COPP				Interval Between Onset and Death
Examine	er	Conventionly list conditions	h. =							<i>O</i>
od sit	iner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
. Box 68760, death certificate be executed e attending physician and d for use as the burial-transit	Fxaminer	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						
68760, fificate be ex physician as the burial	Jedical		d							
<b>•</b>			00-16							
Box eath cer attendir for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1□Live birth 2□Fet 4□Pregnant at time of	tal death 3 □	Ectopic pregnancy Other (specify)	y		23d	. Date of del Month	livery Day Year
	Physician/	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□Unknown							
COrdS, P w requires that been signed b should be deta	5 A		s contributing to death but not re-	sulting in the un	derlying cause giv	ren in Part I.	1. A.			the cause of death?
ord requir	pate		10 To				1 <b>(X</b> )			robably 4  Unknown
Hecords, P.O. The law requires that the tee has been signed by the lage 2 should be detache.	Completed						24a. Was a autops perfor	sy	prior to death?	utopsy findings available completion of cause of
	a	25. Was case referred to medical				26. Place of Deat		med? 2000 No	1 □ Yes	2 □ No
OF VI Physici this cer al direct	L C	examiner? 1 ☐ Yes 2 1 No	Hospital: 1 1 Inpatient 2	☐ ER/Outpatien	t 3□DOA Oth	er: 4 Nursing Ho			Other (Spe	cify)
DIVISION OF  I or Attending Phy after death.  Director: After this d in by the funeral di			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	y at k? Yes 2 □ No	28d. Describe ho	ow injury o	ccurred	
Attended death death sector:	ficat	2 Accident investigat 3 Sulcide 6 Could no	be 28e. Place of injury - At h	 home, farm, stre			28f. Location (S	treet and N	lumber or Ri	ural Route Number,
DIN tal or sa after al Din ed in t	Certification:	4 Homicide determine	building, etc. (Spec	city)			City or Tow	n, State)		γ.
DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after cleath.  To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical		Physician: To the best of my kn aminer: On the basis of examin and manner states.		estigation, in my	opinion, death occur				
To t To tl	M	29b. Signature and title of certifier	J Hux	Ivan	29c. Licens	0.111		633		1 2006
2		30. Name and address of person w	no completed cause of death (Ite	em 23a) (Type, I		r Der	ENSE	A16	HWAY	ANNAPOLINA,
	State	OCT 1	32. Registrar's Sign	nature	Acart .					1140/
Regi	strar	001.1		15' 1						

			1 - For State Registrar	State of	Marylan		artment of H		ind Mental H	ygiene Reg: No.	)6	32849	
	Physici		Decedent's Name (First, Middle,	Doris l	Bender	Smoot			2. Date of Month	Death Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, or	Location o			4c. County of Death		
			Carroll Hospita	al Center			Westmi	nster		Ca	rroll		
	Funeral		5. Social Security Number 6	. Sex 7 1 ☐ M 2 💢 F	. Age (In yrs.	**	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of l (Month,	Birth Day, Year)	Cou	place (State or Foreign	
	Director		217-28-8361 Usual Residence of Decedent	1	72	Yrs.			Jan. 8	3, 1934	Penn	sýlvania	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits	
	Man,	tor	Maryland Carro	11	ŀ	W	estminste	r				1 ☐ Yes 2 🙀 No	
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	23e c	alD	667 Lake Drive	<u> </u>			21:	158		Unite	d Sta	tes	
	er dea	Funeral	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig n, Mexican,	gin? (Specify Yes or I , Puerto Rican, etc.)	No- 14. R	ace - Ameri		
36	s afte	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dal	_		1 ☐ Yes 2X No	Specify:		Spec	eify: Whi	to	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Iteme 23a or 28a-f show int, I've Medical Exami, ar must be molified at		15. Decedent's			16a. Dece	dent's Usual Occupa	ation		16b. Kind of			
212	Media	plet	(Specify only highest Elementary/Secondary (0-12)		10r 5+)	(Give	kind of work done o DO NOT use retired	during most )	of working	700. 14110 01	000111000	addity.	
212	d with giene er the	Completed	12	College (1-	401 3+)	Baı	nk Teller			Ban	king		
2	be file ntal Hy od othe	Be (	17. Father's Name (First, Middle, La	,					r's Name (First, Midd		ame)		
altimore, Maryland	should I	To	Victor H. Bend						allie G. (				
Zar Zar	CA 40 = 62		19a. Informant's Name/Relationship		, ,				r or Rural Route Nun				
o,	1 and Health em 27 ther tr		Lloyd Duvall Smoo	ot, III/Hu	ISDANG 20b. P		ake Drive	e, wes	stminster,	Mary Lar			
no	Pages nent of thant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate	emetery, crei	natory or other place	100	ctober 17,				
፟፟፟፟፟፟፟፟	permit. Page Department of Important: If any Injury or once.		21 Signature of Funeral Senece Lin	99299		2	Memorial F 2. Name and Addres	e of Eacility	2006			Maryland	
ñ	Ded fine per per per per per per per per per pe		23a. Part 1. Enger the disease, or co		M0019	Rc 20	bert A. E	umphr	ey Funera	1 Home/I	Rockvi	11e, Inc.	
19,			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cal	used the death	h. Do not ent	er the mode of dying	g, such as o	cardiac or respiratory	arrest,	<del>2, MU,</del>	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			EELL	LUNG	tan	ICER			Onset and Death	
	/Medical		resulting in death)	а.	r as a consequ								
Ac	Examiner	_	Sequentially list conditions.	b	meson by the								
M	led sit	nine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	as a consequ	uence or;							
- b	al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	uence of):					-		
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cail		d									
9	tificat ng ph) as th	Physician/Medical											
Box	death certifici attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna th 2 □ Fetal		Ectopic pregnancy			i	ate of delive	,	
П	e dea the at	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of de		Other (specify)			. N	Month	Day Year	
P.O.	res that the designed by the a	Phy	Part II. Other significant conditions	s contribution to dea	th but not resu	ulting in the u	nderhing cause awa	on in Part I	23a Dir	1 tobacco usa co	ntributa to ti	he cause of death?	
Vital Records,	signe d be	d by			551 1151 1331	annig in the a	noonying cause give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 No		1.	
Sor	w require been si should b	Completed							24a. Wa	-			
Re	The law cate has page 2:	ш							aut	opsy formed?	prior to co death?	psy findings available impletion of cause of	
ā		6)	25. Was case referred to medical					00 Di	1 Yes		1 🗆 Yes	2□ No	
	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	patient 2	ER/Outpatier	t 3 DOA Othe	P*	of Death Check only sing Home 5 Re	9-11	ther (Specif	ivi	
Division of	£ = =		OZ Manner of Dooth	28a. Date of		28b. Time of				e how injury occu		y)	
Ö	death. ctor: All y the fur	atlo	Natural 5 Pending 2 Accident investigat	ion	Day reary	Injury		es 2 N	lo				
$\frac{8}{2}$	or Atter after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 286. Place o	f Injury - At ho	me, farm, str	eet, factory, office		28f. Location City or T	(Street and Nun	nber or Rura	il Route Number,	
	oital o urs af oral D			1									
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	29a. Certifier  (Check only one)  1X Certifying 2 ☐ Medical Ex	Physicien: To the bas aminer: On the bas and manne	is of examinat	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	e, date and inion, death	place, and due to the n occurred at the time	e cause(s) and n e, date and place	nanner as si a, and due to	tated. the cause(s)	
	To the within To the comp	M	29b. Signature and title of certifier		10		29c. License			29d. Date sign			
	1		1 de	~	-ce		レ	302	63	10	-12-	7	
	19		30. Name and address of person where FRANCIS KHO	o, MD	SO W	ismort	AL AVE, 1	N 55 T	MINSTER,				
	Sta Registr		31. Date filed (Month, Day, Year)	006 32 Re	gistrar's Signal								

		1	For State Registrar	State of Ma	ryland		rtment of H tificate of L		and Me		iene g. No.	006	32850	1
			1. Decedent's Name (First, Middle, L							Date of Deat Month October		2006	3. Time of Death	
	Physicia /Medic	al	Robert Ashby							otober			5:00 A M	-
	Examin		4a. Facility Name (If not institution, g Copper Ridg		lome		4b. City, Town, or Svkes	SVILL			4c. Coi	unty of Death Carro		
	E				(In yrs. las	t birthday)	If Under 1 Year	If Under		Date of Birth	Voas		place (State or Foreign	-
	Funeral Director		226-20-0922	1 <b>反</b> M 2□F	81	Yrs.	Months Days	Hours	Min.	Date of Birth (Month Day Pril 2	192		jinia	_
	D 200		Usual Residence of Decedent  10a. State 10b. County	99	10c. City, 7	Town or Lo	cation						10d. Inside City Limits	_
	/anyla		Maryland Howard			്റി	umbia						1 ☐ Yes 2 Mg No	
	r 28a-	rect	10e. Street and Number		-		10f. Zip Code			1	0g. Citizen	of What Cou	intry?	
	th with	al D	6306 Setting Sta	r			2104	5			U.S.			
	tams rrms	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.		Vas Decedent of H f Yes, specify Cuba	ispanic Ori ın, Mexicar	igin? (Specif n, Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Amer Black, White		
2	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1   Yes 2   N  If Yes, Give  Year or Dates:	1946	_   .	I□Yes 2█No	Specify:			Sp	ecify: Wh:	ite	
3	2 hou atura		15. Decedent's	Education		16a. Deced	lent's Usual Occup	ation	t of working		16b. Kind	of Business/Ir	ndustry	
7	ithin 7 19.	ompleted	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	+)	life. l	DO NOT use retired	1)			II C	Post	Office	
7	be flied within 72 hours after death with the Maryland and thygiene. d other than "natural", or Itams 23a or 28a-f show avant, the Medical Examinar must be notified at	O	17. Father's Name (First, Middle, La	Z ct)		POSTA	l Inspec		er's Name (/	First, Middle,			DITICE	-
_	m - 0 2	o Be		ster Sisk					•	Wade				
<u></u>	2 should be filed within and Mental Hygiene. is marked other than sumatic avant, the Ms	5	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Numb	er or Rural F	Route Number			ip Code)	
, Ma	and 2 ialth a ialth a n 27 is		Carolyn Sisk (W	life)			Setting			mbia, N				
e e	of He of He it it it it it it it it it it it it it		20a. Method of Disposition 1 □ Burial 2 XCremation 3	□Removal from State	20b. Plac	ce of Dispo netery, crer	sition (Name of natory or other plac		Dat			ion - City or T		
altimore,	Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Spe	cify)	Metr		ematory 2. Name and Addre		10–11-	-2006	Cato	nsville	e, Maryland	-
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 its marked any injury or other traumatic av <u>once</u> .		21. Signature of Funeral Service Lic	W.			Witzke F 5555 Twi	unera	1 Home	es, Indo	i Lumb:	ıa, MD	21045	
	100		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each lin	the death.	Do not ent	er the mode of dyin	ng, such as	cardiac or r	respiratory arr	est,		Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition	_a. Dem	entra								Years_	_
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):							111111111111111111111111111111111111111	
		-ia	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):							-	-
/	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										_
o Î	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):								
8760	cate be executed obysician and the burial-transit	dicai		d.								-		
9 X	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as:	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	су					230	d. Date of deli	very	
Вох	death a attend	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			∃Ectopic pregnanc; ∃ Other <i>(specify)</i> _	y				Month	Day Year	
g.	res that the de signed by the a be detached t	hysi	9 Unknown	9□ Unknown										_
	es tha gned be del	by P	Part II. Other significant condition	s contributing to death b	ut not result	ting in the u	inderlying cause gr	en in Part	I.	23e. Did to	i		the cause of death?	
ord	w require been si should l									-				_
Sec	e law has b	ompieted						-		24a. Was autop perfor		prior to death?	topsy findings available completion of cause of	
Vital Records,	n: Th ficate rr, pag	O	25. Was case referred to medical					26 Plac	of Death /	1 ☐ Yes (Check only o	-	1 🗆 Yes	2□ No	_
Ĭ	s certi	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatie	nt 3 DOA Ott			e 5 ☐ Resid		Other (Spec	cify)	
٥	g Phy ter thi		27. Manner of Death	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o	of 28c. Inju	ry at rk?	28	d. Describe h	ow injury o	occurred		
Sior	death. ctor: Af	catic	2 Accident investiga	ation				]Yes 2 □		76 Lanation /6	troot and I	Viembos os Di	um I Routo Number	_
Division of	or A fiter Dira in b	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Flace of Iti	jury - At hon tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28	City or Tow		vulliber of ML	ıral Route Number,	
	a Hospital 24 hours a a Funeral C		29a. Certifier 1 Certifying	Physician: To the best	of my know	rledge, dear	th occurred at the ti	me, date a	and place, ar	nd due to the	cause(s) ar	nd manner as	stated.	-
	na Hos na Fur bletely	edical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examination	on and/or ir			ath occurred					_
	To tha 2 within 2 To tha complet	Z	29b. Signature and title of pertifier				29c. Licen		pros.	i i	/	signed (Monti	h, Day, Year)	
	_ t		· wwo	Ih Mr.			1 00	505 8	513	)	10/	11/0/	2	
-	(ax)		30. Name and address of person la		death (Item	A	. Print) e St 30	7 01	lect.	unstor	- 111	211	57	
	st	ate	31. Date filed (Month, Day, Year)	32 32 ist	rar's Signati	ure			()100	11 -1	201			
	Regist		OCT 1 7	2006	re di	K A	sell !							

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State o	of Marylar		artment rtificate			nd M		iene <sub>eg. No</sub> 2	006	3	2851
Division			1. Decedent's Name (First, Middle, Las	·							2. Date of Dear		Year		Time of Death
Phys /Me	iciar edica		Delores Inez Sm								October	14	2000		O15AM
Exan	nine	ľ	4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, T		ocation of			4c. C	ounty of Dea	th	
Euros	101		Harbor Hospital  5. Social Security Number 6. Se	ex .	7. Age (In yrs.	last birthday)		Year	timor		8. Date of Birth		9. Bi	thplace (	(State or Foreign
Funer Directo				□M 2 <b>∑</b> ф F		8 Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day Sept. 2	1,19	48 Ten	ness	
pu »		-	Usual Residence of Decedent  10a, State 10b, County		10c Ci	ty, Town or Lo	cation							10d In	nside City Limits
anyla •hov			Maryland Baltim	ore	100.01	Balti									☐Yes 2⊠No
the N 28a-1	Ctooric	2	10e. Street and Number				10f. Zip (	Code			1	0g. Citize	n of What C	ountry?	
death with the Maryland ime 23s or 28s-f ehow it trivet to notified at	2	2	4322 Fairhaven A	venue			2	1226				U.	S.A.		
deat	i execution in		11. Marital Status	12. Was Dec Armed Fo	edent Ever in U		Was Decede	ent of His	panic Origi Mexican.	in? (Spec	cify Yes or No-	14	Race - Am Black, Whi		dian,
s after	Ü	חיי עמ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gi Year or □	ve T		1 ☐ Yes 2		Specify:			S		√hit∈	2
2-UUS af 72 hours af natural', or lical Exam	7		15. Decedent's Ed		ales.	16a. Dece	dent's Usual	Occupat	ion	_		16b. Kind	of Business		
And Table	3	Completed	(Specify only highest gra	de completed) College (		(Give	kind of work DO NOT use	done du retired)	iring most	of workin	ng				
A with	1	5		3		Cust	comer						Roote	er Co	٥.
Tally Italia Z IZ IS-0030 2 should be filed within 72 hours after death with the Marylan and Mental Hygene. Banked other then "natural, or Itame 23s or 28s-1 show sumatic event, the Hedical Exacil or matter notified at	a	מ	17. Father's Name (First, Middle, Last)								(First, Middle, i iknown	Maiden Si	umame)		
hould d Mer marke	F	2	Coy Watson  19a, Informant's Name/Relationship (1)	vne Print)		19h Maili	na Address /	(Street at			RIOWII Route Number	City or 1	Town State	Zin Code	a)
Ma Jith an 27 Is I				sband)		(	-				altimore				•,
Is 1 ar		Ť	20a. Method of Disposition		20b. I	Place of Dispo cemetery, crei	sition (Name	e of her place	)	Da	ate	20c. Loca	tion - City o	Town, S	State
Page Page nent c ent: If ury or			1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State	ro Cre				0–16	-2006	Cato	nsvil	le, N	Maryland
DarkimOre, Maryland ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If It fam 27 is marked at the rine treatural; or tame 23s or 28s-1 show any injury or other traumatic event, the Medical Exacial actimatic and infined at	once		21. Signature of Funeral Service Liber	tack	na	_   <sup>2</sup> V	vitzke 5555 T	Fun Win	eraliy Knoll	Home s Ro	es, Inc.	umbi	a, MD	2104	45
Dhysisis			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on e	each line.			,	such as c	ardiac or	r respiratory arr	əst,		Inter	roximate rval Between et and Death
Physicia /Medica	al		disease or condition resulting in death)		Or as a consec		(TH)	n.A						·m,	rediate
Examine	ш.		Sequentially list conditions.	b. Con	(or as a consec	BITTER	Y Dis	se as	e					Te.	s/c
l be is		Cyalline	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											4,	
xecut n and al-trar	3	Ya	that initiated events resulting in death) Last	c. Due to	PENTER (or as a consec	quence of):								15,	PAI
COIDS, F.O. BOX 08/00,  w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	100	nical	(		abetes 1										
difficat difficat as th	Podi	2	IF FEMALE:												
ath cer attendir for use	740	and	23b. Was decedent pregnant in the past 12 months?	1□Live I	tcome of pregni birth 2  Feta	al death 3	Ectopic pre					23	d. Date of de	livery Day	Year
he de	9	rnysicianime	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Prega 9□ Unkn	nant at time of d lown	leath 5	Other (spe	cify)							
ords, F.C requires that the een signed by the	9		Part II. Other significant conditions o	ontributing to d	leath but not res	sulting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	pacco use	contribute t	o the cau	use of death?
w requires to been signs should be	7	Completed by	CHRON CZENOL F.	ALLUNE	>						1 🗆 Y	s 2 🗹	No 3 □ P	robably	4 □Unknown
eco law re es bec	100	S S	CHRON-CRENDL F.	ATTO							24a. Was a autops	n	24b. Were a	utopsy fi	ndings available ion of cause of
The law the hes b		5									perform	med'/	death?		
VICAL TO ICIAN: The Certificete hi	0	מ	25. Was case referred to medical examiner?	Hospital:				0.1		of Death	(Check only on	10)			
Phys.	F		1 ☐ Yes 2 ☑ No  27. Manger of Death	28a. Date		ER/Outpatier			4 🗆 Nui		ne 5 🗆 Reside			ecify)	
nding th: : Afte	1		1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mor	nth, Day Year)	Injury	м	c. Injury Work? 1 □ Y	es 2∐N			, ,			
LIVISION  I or Attending efter death. Director; After	.	Cermication	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	e of Injury - At h ling, etc. (Speci	ome, farm, sti	reet, factory,	office		2	8f. Location (Si City or Town		Number or F	ural Rou	ite Number,
urs eff	ě	2													
Hosp 24 ho Fune stely f		edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exen	niner: On the b											cause(s)
UNISION Of VITAI Her To the Hospital or Attending Physician: The law within 24 bours elife death. To the Funerel Director: Atten this certificate hes completely filled in by the funeral director, page 2	3	ğ Z	29b. Signature and title of-certifier				29c.	License	number		2	9d. Date	signed (Mon	th, Day,	Year)
- 3-0			DNO	Resai B.	IKOV!	tami	I	000	6143	8		Detal	ser 1	4.	2006
1		-	30. Name and address of person who	completed cau	se of death (Ite	п 23а) (Туре,	Print)								
2			31. Date filed (Month, Day, Year)	DUKON	egistrar's Sign	3 atare	001 Sc	uth	Hanov	ær S	St. Balt	imor	e, MD	212:	30
	State İstra		nct 1 7 20	06	ر معاملاً	y A	3400								

			For State	State of Maryla	-					32852
			Registrar  1. Decedent's Name (First, Middle, Las	**1	Cer	tificate of L	Jeam	Reg	g. No.	3. Time of Death
	Physici	an	GARV	TAILEV	,			Month	Day Year	8:35P M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4h City Town or	Location of Death	octoBER	10 2006 4c. County of Death	8.221
	Examin	er			FOSP, T		A	RE	4c. County of Death	
-	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		217-56 0786 1	12M 2 F 5	Yrs.	Months Days	Hours Min.	Dec. 18		MD MD
	D.		Usual Residence of Decedent			-				
	arytar Show	<u>.</u>	10a. State 10b. County N	A 10c.	City, Town or Lo	cation				10d. Inside City Limits 1  Yes 2  No
	Ba-f	Director	MD			Baltin	ore			
	with the		10e. Street and Number	_		10f. Zip Code		10	g. Citizen of What Cou	ntry?
	s 23	erai	11. Marital Status	12. Was Decedent Ever in	0116 123		AIAIC	activ Voc or No	14. Race - Ameri	Can Indian
"	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	etional	Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black, White,	
93	al', o	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 20046	Specify:		Specify:	ack
5-0	d within 72 hours after death with the Maryland Jiene. Ir than "natural", or items 23a or 28a-f show The Macical Examinar must be notified at	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a. Deced	lent's Usual Occupa	ation during most of worki	na 1	6b. Kind of Business/In	dustry
21	within 7	햩	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired				
2	e filed value of Hygie other t		17. Father's Name (First, Middle, Last)		Mair	tenanc-	18. Mother's Name	/ISOY		nance
Maryland 21215-0036	a la b	Be	TI	lev, Sr.			· 1 · -	(1 II SI, WILCOLE, WIL	\ \ •	
2	d 2 should th and Men 7 is marke treumatic	ဍ	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a	and Number or Rura	I Route Number.	City or Town, State, Zij	c Code)
	d 2 Tha Tree		Adrienne Rich	ardson /nie					ND ala	-
ā,			20a. Method of Disposition	20	b. Place of Dispo	sition (Name of natory or other place			Oc. Location - City or T	The latest and the la
Ë	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Crementi	, I	7-06 1	M. Ottos	D
Baltimore,	permit. Pages Department of I Important: If It eny injury or o'		21. Signature uneral ervice Licen	\$00 )		. Name and Addres			5	
<u> </u>	89 = 8	5 1	1 Jewood	I hand	I	-AM 12	3a Midi	alley D	r. Jessup	, PA 18434
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	olications that caused the done cause on each line.	eath. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Meta	stali	e d'u	ng	Canc	u	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of);					
	_	-	Sequentially list conditions,	b. Due to for as a con-	sayuanica vil).					
	uted A B	Examiner	any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	exec en an		resulting in death) Last	Due to (or as a con-	sequence of):					
8760,	The law requires that the death certificate be executed the same signed by the ettending physicien and agge 2 should be detached for use as the burial-transit	dicai		. d						
ဖ	ing ph	0	IF FEMALE:							
Вох	eath certific ettending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
0.	at the de by the e	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5	Other (specify)				,
<b>a</b>	that the		Part II. Other significant conditions c	ontributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Vital Records,	uires n sign ild be	d by						1 ☐ Yes	2 □ No 3 □ Pro	pabiy 4 Dunknown
20	aw requir is been s 2 should	ompleted						24a. Was an	24b. Were auto	opsy findings available impletion of cause of
æ	The ta	mo						autopsy perform	ed? death?  ☑ No 1 ☐ Yes	
ita		BeC	25. Was case referred to medical				26. Place of Death			
of <	S 5	ToE	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Hor	me 5 Residen	nce 6 Other (Speci	(y)
u o	De Fig.		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work	c?	28d. Describe hov	v injury occurred	
sio	E sa E	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	20/ 1 /01		
Division	tel or Attendits stater death.  June Director; A sed in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	nt nome, tarm, str ecify)	eet, factory, office	'	City or Town,	eet and Number or Run State)	al Houle Number,
_	Hospital or 24 hours afte Funerel Dir tely filled in b		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, death	occurred at the tim	ne, date and place, a	and due to the cau	use(s) and manner as	stated.
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by ti	edicai	(Check only 2 Medical Examone)	niner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my or	pinion, death occurr	ed at the time, dat	te and place, and due t	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0 11.	7	29c. License		_	d. Date signed (Month,	
			Kopión	1. Cru	Low	> 00	03035	7 0	ctober	10,2006
	3		30. Name and address of person who	completed cause of death (	Item 28a) (Type,	Print)	PALL	= 0 0 . 1 .	20 Mar	10,2006 PITAL
	Sta	i a	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature		UN SE	Cau/	-S 1708)	MAL
**	Registr	-		06 Janes	J. J. Sagar	sales!				

### Please Type or Print in Black Indelible Ink

Robert Charles	•	e 1- For State	State	of Maryland		artment o		and	Menta	al Hygi	ene			
Physicia		Registrar  1. Decedent's Name (First, I	/liddle,Las	t)	001		Dealli				Date of Deatl		06	Time Death 5
Medical Exami	1111	Robert Cha								ď	Month October 12	Day Year 2, 2006		2238 hrs
		4a. Facility Name (if not inst	tution, giv	e street and number	)		4b. City, Tov	vn, or L	ocation of			4c. County of I		
		8004 Gray Haven	Road				Dundall	k				Baltimore	County	′
Funeral		5. Social Security Number	6. Se		ge (In yrs. I	ast birthday)	If Under	1 Year Days	If Under	_		h(MM/DD/YYYY)	oreign	
Director		219-78-317	$b \mid_{1} X$	M 2 F		41 <sub>Yrs</sub>		Days	Tiodis	0	9-15-	-1965	Countr	y) MD
,	-	Usual Residence of Deceder 10a, State 10b, Cor			Inc. City	, Town or Loca	tion		,				10	d. Inside City Limits
ow any			,	ore Co.		ndalk								Yes 2XXNo
ryland a-f sh	흸	10e. Street and Number		020 001			10f. Zip Co	ode			10	g. Citizen of What		
vith the Maryland s 23a or 28a-f show a enotified at once.	ië	8004 Gray	Цол	on Pood			212					USA		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Departmet of Helland Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status	iiav	12. Was Deceden	t Ever in U	.s. 13. Wa	as Decedent	_	anic Origin	n? (Specif	y Yes or No-		American	Indian, Black,
eath vitem	nu	1 Never Married 2	Married	Armed Forces	? 		es, specify (					White, e		
after d II", or ner m	by Fi	3 Widowed 4	Divorced	If Yes, Give Year	X	1	Yes 2	No	specify:			Specify: [	<i>N</i> hit	e
ours a		15. Decedent's Education	Specify or			16a. Deceder	nt's Usual Oc nost of workin					16b. Kind of Busin	ness/Indu	stry
6 n 72 h an "n iol E	jet	Elementary/Secondary (0	-12)	College (1-4 or	5+)			ig iiio. z	JO 1101 G	30 1001007		_		. 1
within tiene the Medi	Completed	9 17. Father's Name (First, Mi	della ( aat)	N/A		l M	ason	Lac	Mathada	Nama (Fie	a Middla N	Const	ruc	tion
215-0036  De filed within 7  Tital Hygiene  Red other than  ent, th. M. dir	BeC	Marvin Ty						'		•		erwinsk:	:	
212 ould be Menta mark	TO B	19a. Informant's Name/Rela		ype, Print )		19b. Mailin	g Address	(Street				ber, City or Town,		Code)
MD nd 2 sho alth and m 27 is		Theresa Ca	rr -	Sister		10 B	each	Dr	ive :	Dund	alk,	MD 2122	22	
e, P. I and Health Health item		20a. Method of Disposition				Place of Disport	sition (Name				ate	20c. Location - C		vn, State
Baltimore, permit Pages Lar Department of Hee Important: If ite		1 Burial 2 Crem 4 Donation 5 Oth	ation 3   er <i>Specify</i> .		are	-	-	itoi	. <sub>v</sub>	10-1	3-06	Baltimo	)re	MD
altir mit F partme portal	ŀ	21. Signature of Funeral Se			<u> pa</u>	22.1	Name and Ac	dress	of Facility	Kacz	orows	ski Fune	eral	Home, P
<b>9</b> 2 2 1 1		Well He	_									altimore		D 21222
Physician		23a. Part I. Enter the diseas failure. List only one c			the death	. Do not enter	the mode of o	dying, s	uch as car	diac or res	spiratory arre	est, shock, or heart		pproximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final dis	ease a.	Complications	of Liver	Cirrhosis								Death
		or condition resulting in dea	th)	Due to (or as a cons	equence o	of):								
	ᡖ	Sequentially list conditions, if any, leading to immediate	b.	Due to (or as a cons	equence o	of):							$\rightarrow$	
	Examiner	cause. Enter Underlying Ca (Disease or injury that initia	ed C.											
ag _ de	Exa	events resulting in death) l	ast	Due to (or as a cons	equence o	of):							100	T
6 be executed sysician and burial - transit	edical	UNPENDED		AMENDED		=						***		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Jed	IF FEMALE:		23c. If yes, outco	me of pred	nancy						23d. Date of de	elivery	
Box 6876( death certificate the attending phy	an/M	23b. Was decedent pregnan past 12 months?	in the	1 Live birth	0. p. 03		etal death	3	Ectopic p	oregnancy		Month	Day	Year
OX (	sici	1 Yes 2 No 9	Unknown	4 Pregnant a	t time of de	eath 5 0	ther (Specify	<b>(</b> )						
D. B.	Phy	Part II. Other significant co	nditions	9 Unknown	th but not r	resulting in the	underlying ca	ause oiv	en in Part	1	23e. Did to	bacco use contribu	ite to the	cause of death?
P.O.	<u>ج</u>	Chronic Ethanolis		oom batting to doo	Dat mot n	ooditing in the	an labiny mig oc		on an			2 No 3		
ords, P.O. w requires that the as been signed by a should be detached.	Completed									- 1	24a. Was a	an   24b. We	ere autops	sy findings available
COF law re has b	휠										autops perfor		or to comp ath?	oletion of cause of
tal Rec	ટી					<del></del>		-			1 Yes 2	2 No 1	/ Yes	2 No
Division of Vital Records, lad or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	å	25. Was case referred to me examiner?		Hospital: 1 Inpati	ent 2	ER/Outpatien		10	thor	Check only Nursing H		Residence 6	Othor Se	
n of Vi Jing Physi After this funeral dir	읟	1 Yes 2 No		28a. Date of Inj	ury	28b. Time of			at Work?			now injury occurred		erie
ion c tending eath. for: Af the fun	틸	1 Natural 5	Pending	(Month, Day,	Year)			1 Ye	s 2 N	No				
riSic r Atte er dez irecto	Certification:	2 Accident 3 Suicide 6	Investigati	28e Place of I	njury - At h	nome, farm, stre	et, factory, o	ffice bu	ilding, etc	28f	f. Location (S	treet and Number	or Rural I	Route Number, City
Divis pital or At ours after d eral Direc	Ē	3 Suicide 6 Homicide	Could not determine								or Town, St	tate)		
Hospita 24 hours Funeral		20a Cadifier	ng Physic	ian: To the best of n	ny knowled	ige, death occu	irred at the tii	me, date	e and plac	e, and due	e to the cause	e(s) and manner as	s started	
Division To the Hospital or Attent within 24 hours and To the Funeral Birrectors completely filled in by the	Medical		Examine	r:On the basis of exa		and/or investiga	ation, in my o	pinion,	death occi	urred at the	e time, date a	and place, and due	to the ca	ause(s)
F 3 F 8	ž	29b. Signature and title of c	ertifier	1011			29c. l	icense	number			29d. Date signed	(Month,	Day, Year)
		Mulissa /2	las	well Mt	}			D.C.M	l.E.			October 13, 2006		
1		30. Name and address of po			,	,								
`		Melissa Brassell,		ssistant Medica			Penn Stre	et, Ba	ıltimore,	MD 21:	201			
Si Regis	tate	31. Date filed (Month, Day,)	ear) 1 7 7	32. Registr	ar's Signat	ore /	and I							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	1arylan		artmen rtificat			and M		Reg. No.	006	32854
3	Physici		1. Decedent's Name (First, Middle	Vagy	+ies						2. Date of De Month Octobe	Day	Year 2006	NA
	/Medio Examir		4a. Facility Name (If not institution 3523 Scarboro	n, give street and number		·	4b. City,		Location o	of Death	occore	4c.	County of De	ath
A	Funeral Director		5. Social Security Number 218-54-0273		ige (In yrs.	last birthday) Yrs.	If Under Months	1 Year	If Under: Hours	Min.	8. Date of Bir (Month, Da Dec. 20	y, Year)	9. B 49 Ho	irthplace (State or Foreign Country) 11and
	Maryland f ahow	tor	Usual Residence of Decedent  10a. State  10b. County	ford		y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2€ No
	or 28a	Director	Maryland Har 10e. Street and Number	LOLA	اد	LIEEL	10f. Zip					-	zen of What (	Country?
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If tier 27 is marked other than "natural" or Itema 23a or 28a-f show important: If tier 27 is marked other than "astural" or Itema 23a or 28a-f show any injury or other traumatic avant, the Mcdical Examinar must be notified at once.	by Funerai	3523 Scarboro :  11. Marital Status  1 Never Married 2 Marriad 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2 5	s? <b>≹</b> No		Was Decedif Yes, special Yes	cify Cuba	spanic Orio	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)			nencan Indian, nite, etc. White
Maryland 21215-0036	ithin 72 hou ne. nan "natura Madical E	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)  College (1-40)	r 5+)	life.	kind of wo DO NOT u	rk doné d se retired	turing most )		ng		nd of Busines	s/Industry
LZ D	filed w Hygier other th	e Cor	12 17. Father's Name (First, Middle,	Last)		Pro	duce	Supe:	rviso 18. Mothe		(First, Middle		OCETY Sumame)	Store
ylan	Mental Mental Brked atic av	To Be	Kornelis (nmn	) Vaartjes		.,			Cor	neli	a (nmr	1) S	chotar	nus
Mar	d 2 sho th and th and traum		19a. Informant's Name/Relations Kathy A. Vaart				-				<i>Route Numb</i> reet, N	-		
Je,	of Heal		20a. Method of Disposition		20b. F	Place of Dispo					ate			or Town, State
Baltimore,	Page tment tant: If jury or		1   Burial 2 ☐ Cremation  Donation 5 ☐ Other (S	Specify)	8	l Air N	Memor	ial	1					Maryland
Ra	Departition Depart		21. Signature of Funeral Service	1 muel		22	2. Name ar 50 <b>We</b>	McCo St B	is of Facilit Omas roadw	Fune ay,	ral Hon Bel Air	ne, P , Ma	A. ryland	1 21014
Arr.	Physician /Medical		23a. Pan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		biral	edem		te of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
-	Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and related director, page 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		odeno	troplic uence of):	ma.							12 years
P.O. Box 6	res that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	Ideath 3	⊒Ectopic p ⊒ Other (sµ					2	23d. Date of d Month	delivery Day Year
rds, r.	w requires that in the properties of the propert	٩	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the u	inderlying o	ause givi	en in Part I.					lo the cause of death? Probably 4 □Unknown
I Records,	The law re ate has bee page 2 sho	Completed							0		24a. Was auto perfo 1 \( \text{Yes}	psy ormed?	24b. Were prior to death'	
VIta	sician certific rector,	Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:		ED/O		Othe	ar.		(Check only			
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	28a. Date of In (Month, E		28b. Time o Injury		28c. Injun Worl	4 🗀 140	:	me 5 Resi 28d. Describe			овсту)
DIVIS	tal or Atters after desail Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd 200. Place of I	njury - At h etc. <i>(Specii</i>	ome, farm, st	reet, factor	y, office			28f. Location ( City or To			Rural Route Number,
	Hospital or 24 hours afte Funeral Dir etely filled in	Medical		ng Physician: To the best Examiner: On the basis and manner:	of examina									
	To the To the comple	Me	29b. Signature and title of certifie				29	c. Licens	number			29d. Dat	e signed (Mo	nth, Day, Year)
	T		& L. Queste		ms .			D	2380	9		Oc	tober	12,2006
	Sta Regist		30. Name and address of person  L. Fuzho Do  31. Date filed (Month, Day, Year)					s Ctr	., 2.	2 S.	Greene	St.,	Balt	., mo 2120;

			For State	State of Maryland / [	•	nt of Health and I te of Death		711116	32855
			Registrar  1. Decedent's Name (First, Middle, Last)		Oerunca	te or Death	2. Date of Dear	h	3. Time of Death
	Physici /Medi		Dologes (	2. WOLF			OCIOS 5	Day Year	3:04 PM
	Examir		4a. Facility Name (If not institution, give s		4b. City	y, Town, or Location of Death	1	4c. County of Death	
			5. Social Security Number 6. Sex	JEAKE HOSPIT	tholaw If I look	er 1 Year If Under 24 Hrs.	P. Date of Righ	HERFO	LO Contra ou Francis
- 1	Funeral Director			M 219 F 8	Yrs. Months		8. Date of Birth (Month, Day)	Year) Cou	place (State or Foreign intry)
			Usual Residence of Decedent				11/04-200	1121111111	
	r 28a-f ehow	2	10a. State 10b. County	10c. City, Town	n or Location				10d. fnside City Limits 1 ☐ Yes 2 No
	the M	ect	10e. Street and Number	150 12:	10f. Z	ip Code	1	0g. Citizen of What Cou	
	death with the Maryland me 23a or 28a-f ehow Efficial by rediffed at	i Di	2 5505/5/2/H	PLACE		21014		. A. Z. [ ]	.,
		Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
7	s afte		1 Never Married 2 Married  3 Never Married 2 Married  3 Never Married 2 Divorced	1 ☐ Yes 25 No If Yes, Give Year or Dates:	1 ☐ Yes		,	Specify:	June
1504 21215-0036	within 72 hours after death with ene. Than "natural", or Iteme 23e or the Medical Exacultar medical	Completed by	15. Decedent's Educ	cation 16a.	Decedent's Us	ual Occupation		16b. Kind of Business/Ir	ndustry
56		npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of w	rork done during most of wor use retired)	king	.1	
	D 0 -		-28/61	62	45CK	MOLESTOR	Cina Adidus	MARCO	
and	A la D	Be	17. Father's Name (First, Middle, Last)	56025		18. Mothers Nan	ne (First, Middle,	walden Sumame)	-
o6 Maryland	2 should and Men is mark sumatic	<sup>2</sup>	19a. Informant's Name/Relationship (Type		. Mailing Addres	ss (Street and Number or Ru	ral Route Number	City or Town, State, Zig	o Code) 210317
OZ	s 1 and 2 should f Health and Mer item 27 is marks other treumatic		KAREN WUNDE	R b'	WESLE	12000 Lo	3/ Tru	1 ILLIVESON	IAM/AM
116 more	000		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R	comoto	f Disposition (Na ry, crematory or	ame of other place)		20c. Location - City or T	own, State
	t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (Specify)	J. I.E.			20, 7	Hickory !	Jessy Fevo
/ O Balti	permit. Pag Depertment Important: f any injury o		21. Signature of Falleral Service License		22. Name a	bell Blanch	AUSTAN		SERVICES
			23a. Pert, Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do	not enter the mo	ode of dying, such as cardiac	or respiratory arr	est,	Approximate
	Physician		Immediate Cause (Final disease or condition						Interval Between Onset and Death
9	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	hycardia		The second secon	
+	LAdminer	_	Sequentially list conditions,	Cardia C Due to (or as a consequence		henia			Smister
Q	nsit	Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	oue to (or as a consequence	01).				
0.0	exection and and rial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a consequence	of):				
50	cate be exe physician a the burial-	dicai							
() (9	eath certific ettending p for use as	/Mec	IF FEMALE:	3c. If yes, outcome of pregnancy				00d Date of deliv	
		Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetel death 4 Pregnant at time of death	3 ☐Ectopic (			23d. Date of deliv Month	ory Day Year
A O.	at the de by the tached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown					
S. S.	signed d	þ	Part If. Other significant conditions con	tributing to death but not resulting in	n the underlying	cause given in Part I.		pacco use contribute to t	
O FES	w requir been si should	eted						es 2 No 3 Pro	
Pres	The law ete has b page 2 s	Completed					24a. Was a autops perform	n 24b. Were auto y prior to co ned? death?	opsy findings available ompletion of cause of
$\int_{\mathcal{O}} \mathcal{O} / \mathcal{O}$		e Co	25. Was case referred to medical			26 Place of Dec		No 1 □ Yes	2 No
-	9 10 <del>1</del>	To B	examiner?	ospital: 1 patient 2 EP/Ou	utpatient 3 C	Othor		ence 6 □Other (Speci	fy)
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending		Time of njury	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Jolf Division	E 25 0	Icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	M stroot facto	1 Yes 2 No	28f Location (S	reet and Number or Run	al Route Number
20	affer affer I Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	im, street, racto	ay, once	City or Town		ar riodio reambor.
3	To the Hospital or Atterwishin 24 hours after de To the Funeral Direct completely filled in by the	caic	29a. Certifier Certifying Phys	ician: To the best of my knowledge ner: On the basis of examination an	e, death occurre	d at the time, date and place	, and due to the c	ause(s) and manner as	stated.
	the H hin 24 the F nplete	Medicai	опе)	and manner stated.					
	7. W. O. O. O. O. O. O. O. O. O. O. O. O. O.	-	29b. Signature and title of certifier			9c. License number 400 63/3	8	9d. Date signed (Month,	
	di		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)			10/16/	- / -
	10		Jeffrey Swe	LH 12.0. 500	Me	Chesapeable	17- B	el Aur m	MOIS a
	Sta Regist		31. Date filed (Month, Day Year)	mpleted cause of death (Item 23a)  H I) D - 500  32. Registrar's Signature	10000	,			
	- rogist		00	J .					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** LARRY WATSON 15:31 10 13 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 213-52-1473 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Completed by Funeral Director MARULAND 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOLSTE TURNBULL 1 HAGRADE ENTERPRISES 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of F Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State WOODLAWN, MARVLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final HEMORRHAGE INTRACEREBRAL Physician three days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner ng physician and as the bunial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 X No 3 Probably 4 □Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 No 20 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဠ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Konna Hertzano, M.D. 10/13/2006 17605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONNA HERTZANO, 22 SOUTH GREENEST. BALTIMORE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 OCT 1 7 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death odtbber 3 2006 **Physician** Tillie Warwick 12:48p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Heritage Nursing Home Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 1/07/10 12 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1□ M 2□XF 90 214-01-0628 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show rry or other traumatic avant, the Medical Examinatic avant, the medical Examinatic avant. Dundalk 1 ☐ Yes 2 X No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Center Place Apt 203 21222 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dennis Punko Katherine Sulimczik ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 Elkon Lane Westminster, MD 21157 19a. Informant's Name/Relationship (Type, Print) Raymond Warwick Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit Page Depariment o Important: If any in ury or once. 10/16/06 Evergreen Mem. Finksburg, MD Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Avenue Balto MD 21. Signal of Funeral Service License Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregpant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery ned by the atten edetached for c 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 100 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2010 1 Yes To the Hospital or Attanding Physician: director, 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 2 this after death.
I Diractor: After this d in by the funeral d 27. Manne I Death 1 atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To tha Funaral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated 29b. Signature and A3a) (Type Print) 0-MOPE Registrar's Signature mo State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 32858 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yee WEINKAN Physician DUISE OCTOBER 8:41 A. 2006 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 3, 1917 Catonsville Paradise Assisted Living 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland 1 ☐ M 2 🔀 F 218-03-0156 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City. Town or Location 10b. County 10a, State r than "natural", or Itame 23a or 28e-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 No Catonsville Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 311 Orley Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clerk 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy, Important: If Item 27 ie markad othe eny injury or other treumails avens 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angelina DiGerardi Louis Janney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Orley Road; Catonsville, Maryland 21228 Louis J. Weinkam, Sr. Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 10/16/2006 New Cathedral 4 □Donation 5 □Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fune MD 21228 1630 Edmondson Avenue; Catonsville, Part1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician 2-40s /Medical Due to (or as a consequence of) Examiner METASTASES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 2 No 5 ☐ Other (specify) 4□Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2∏ No 2. No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: at or Attending P efter death. I Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel or within 24 hours eft To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 021649 October 13 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 LIKENS AVE BALTIMORE MO 21229 BASKACAN 3451 SAMBANDAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

DHMH 17 Rev 1/2001

100		Stata Registrar  1. Decedent's Name (First, Middle, Last)	State of Ma		Cer	tificate	OT L	Jeatn ———		2 Date of De.	Reg. No.		32859
Physici		Eleanor Catherin	e Weglei	n						Month Oct.	Pay.	2006	9:00 AM
/Medic Examin		4a. Facility Name (If not institution, give st 4925 Alesia-Lin		ađ			Town, or	Location o	of Death			unty of Death Carrol	
Funeral Director		エとノーローフエブロ	7. Ag	e (In yrs. last b 92	Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird Month, Da	h y, Year) 191	9. Birth Cou New	place (State or Foreign into) York City
nd Mental Hygiene. s marked other than "natural", or iteme 23e or 28a-1 show umatic event, the Medical Exeminat must be notified at	lor	Usuat Residence of Decedent  10a. State 10b. County  Maryland Carroll		10c. City, To	wn or Loc								10d. Inside City Limits 1 Yes 2 □ No
3a or 28a- Il be notif	Direct	10e. Street and Number 4925 Alesia-Lineb	oro Road	I	10f. Zip Code 21102					10g. Citizen of What Country?			intry?
Department of regular and worked other than "natural", or flowe 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at 2008.	Completed by Funeral Director		2. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Deced Yes, spec	-		gin? (Spe	ecify Yes or No Rican, etc.)		Race - Amer Black, White Who	
r than "natur the Madical	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coltege (1-4or 5		a. Deced (Give I life. D Hou	ent's Usua kind of wor OO NOT us LS EW 1	Occupa k done d e retired;	ition luring mosi	t of worki	ng		of Business/Ir emaker	
rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Frederick Roede	r							<i>(First, Middle,</i> rine Go		mame)	
n 27 is ma er trauma		19a. Informant's Name/Relationship (Type James V. Wegle		L	925	Ales	la-L	inebo		d a Mar			
ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place Former Veter	of Dispos TYPET Cans	ceme t	e of her place cery	dp		17, 20		ion · City or T nville	
Import any inj		21. Signature of Funeral Service License	9		22	Name and Ckhai 296 (	d Addres Cdt Char	s of Facilit Funer mil D	al C rive	hapel. Manch	P.A. lester	, Md.	21102
ysician Wedical raminer	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one shock or heart failure. List only one shock or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	e of): ati	Ar	y l S	+					Approximate Interval Between Onset and Death
been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medicat E	in the past 12 months?  1 Yes 2 No 9 Unknown	c. If yes, outcome 1  Live birth 4 Pregnant at 9 Unknown	2 Fetal deat	5 🗆	Ectopic pro	ecity)					I. Date of deliving Month	Day Year
been signed should be d	Completed by	Part II. Other significant conditions contained by Part II.	A /	V T	in the un	P E	ause give	on in Part I		23e. Did t	Yes 2.21	√0 3 □ Pro	the cause of death? babfy 4 Unknown opsy findings availabfe
tificate has tor, page 2	0	25. Was case referred to medical						26. Place	of Death	autor	osy ormed? 2 No	prior to or death?	omptetion of cause of
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion; To B	examiner?  1 Yes 2 No Ho  27. Manner of Death  Natural 5 Pending  2 Accident investigation	1  Inpatie 28a. Date of Inju (Month, Da	ry 28b	Outpatient . Time of Injury		Bc. Injury Work	4 🗀 190		me Resi 28d. Describe			(fy)
I Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of fni building, et	ury - At home, c. (Specify)	farm, stre	eet, factory	, office			28f. Location ( City or To		lumber or Rui	al Route Number,
N 24 mous	Medical C	29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis o and manner st	f examination a	ge, death and/or inv	occurred restigation,	at the tim	e, date an pinion, dea	id place,	and due to the ed at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
To the	Ň	29b. Signature and title of certifier	ans	za m	٥	1		number	043			igned (Month	
		30. Name and address of person who cor	nnleted cause of c	leath /Item 23a	(Type I	Print)	4.				ster		

		1 - For State Registrar	State of Maryland	d / Departmen <i>Certificat</i>	t of Health and I e <i>of Death</i>	Mental Hygien Reg. N	
Physic /Medi		1. Decedent's Name (First, Middle, Las	o lackiting			2. Date of Death Month Di	ay Year 3. Time of Death
Examil Funeral Director		218-14 1020	street and number)    Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)   Street and number)	18	Town, or Location of Deatl  1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth	24 Sinth State or Foreign
Maryland f ahow	tor	Usuel Residence of Decedent  10a. State  10b. County  Rail	more to	Town or Location Candalk	stown	-	10d. Inside City Limits 1 ☐ Yes 2 No
with the 3a or 28a	Funeral Director	10e. Street and Number	t Road	10f. Zip		10g. C	itizen of What Country?
1215-0036 within 72 hours after deeth with the Maryland ene. than "natural", or Itema 23a or 28a-f ahow than "matural" and itema 13a or 28a-f ahow	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates:	S. 13. Was Deced	lent of Hispanic Origin? (S offy Cuban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at gange.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5+)	life. PO NOT us	rk done during most of wor	king 16b.	Kind of Business/Industry C: ty Schools
Maryland 2 Id 2 should be filed Ith and Mental Hygio 77 is marked other traumatic event, II	To Be C	17 Patter's Name (First, Middle, Last) Kubin Keys			Mat	ne (First, Middle, Maide	ias Kins
re, Mar tand 2 sho Health and tam 27 is m		11. Informant's Name/Relationship (7)	a/Wite	19b. Mailing Address  19b. Mailing Address  ace of Disposition (Nariametery, crematery or o	Court Kd. A	pt. 203, t	by Town, State, Z. Code)  and all Fun, ND 2133  Location - City or Town, State
Baltimore, permit. Pages 1 a Depertment of Hei Important: If Itam any injury or othe		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Furer I Serve Liven	Aemoval Irolli State	ng lari	drep shot Ferre	19/06 B ene Funer Randall	alfomore, UD al Services Stown, UD 2/133
Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	dications that caused the death one cause on each line.	. Do not enter the mod	e of dying, such as cardiad		Approximate Interval Between Onset and Death
68760, × ilicate be executed <b>XE</b> physician and <b>W</b> is the burial-transit and in the contract of the contract	edical Examiner	resulting in death)  Sequentially list conditions, if any leadin, to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	J. J.	aretion		
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pr			23d. Date of delivery Month Day Year
rdS, P. quires that In signed by	Ď.	Part II. Other significant conditions co	ontributing to death but not resu	Ilting in the underlying c	ause given in Part I.		use contribute to the cause of death?
21 KeCO n: The law re- licete has bee r, page 2 shoi	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
<b>DIVISION OT VITAL MECONDS, P.O. BOX</b> To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a	ation; To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DC 28b. Time of Injury M		inth (Check only one)  ome 5 Residence  28d. Describe how inju	
DIVISIC  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, street, factory	r, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, (e)
tha Hospi iin 24 hou tha Funer ipletely fill	Medical	(Check only 2 Madical Exam	vsician: To the best of my knowinar: On the basis of examinat and manner stated.	ion and/or investigation	in my opinion, death occu	rred at the time, date ar	nd place, and due to the cause(s)
To with corr	2	29b. Signature and title of certifier	Trings	,	1439 74		ate signed (Month, Day, Year)
Y		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	rospital	120140111	Adam 13, 2006
St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 1 7 20	32: Registrar's Signal	ure April 1			

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12:30 PM M **Physician** october 13, 2006 Lamont T. Winnez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 705 Chesapeake Ave. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1270571969 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign MD Country) **Funeral** 1**X**M 2□F 36 213-82-2295 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910-USA 705 Chesapeake Ave. death Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Hospital 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurses Assistant permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygien importents: If item 27 is marked other this any injury or other traumatic event, the page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francine Lorry Shields Winnez Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3830 Rexmere Rd. Baltimore, MD 21218-19a, Informant's Name/Relationship (Type, Print) Barbara Hawkins/Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 10-16-06 21. Signature of Funeral Service Licensee Rapp Funeral & Exception Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Castleman's Disease vears /Medical Due to (or as a consequence of): Examiner Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last 5 years Due to (or as a consequence of): Examiner the burial-transit the Hospitel or Attending Physician; The law requires that the death certificate be executed Division of Vital Records. P.O. Box 68760. c. Acquired Immunodeficiency Disease 7 years Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗆 Yes this 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 13, 2006 Cynilia M. Dellomo Do H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams D.O. Montgomery Hospice 6001 Muncaster Mill Rd.Rockville, MD20850

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) OCT 1 7 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 32862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:15 AM SARA A. WACKER. October 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Keswick MultiCare Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🐼 F 92 Yrs. 054 30 8985 Director Puerto Rico 16 1914 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Marylar Hygiene.
Other then "nature!, or iteme 23a or 28a-f showent, tre Modical Exeminar must be notified... N/A Baltimore 1XXes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40th Street 21211 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 □ Yes **2√2**No 1 Never Married 2 Married XXYes 2□ No Specify: Basque Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: white þ Specify: 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home of Health and Mental Hygis filem 27 ie marked other r other treumatic event, the Pages 1 end 2 should be filed nent of Health and Mental Hygi ent: If item 27 ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florencio Amoros Victoria Cabrera 2 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francisco Rodriguez Nephew 1559 St. Margarets Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 5 10/14/2006 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 Approximate Interval Between Onset and Death Yelly S 23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Wiferender Cardinascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the ettending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Di abetes mellitus 24a. Was an s certificete hes b lirector, page 2 sl autopsy performed? 1 Yes 2 No is after deam.
rel Director: After this ceru...
in by the funeral director, p. To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in 24 hours.
the Funeral Directory filled in by the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M sahelle D13657 October 13, 2006 tream 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 W. 40 H Street, Backarere, Ted 21211 OF JABELLE MACGREGOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

32863 State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Warfield Robert October 15, 2006 12:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12 Regency Circle Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 15,1961 Birthplace (State or Foreign Country) **Funeral** 1(**X**M 2□F 218-78-0259 45 Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location r then "neturel", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Regency Circle 21090 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 ie marked other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grandville Leonard Warfield Shirley Ann Clause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary DeSales Warfield/Wife 12 Regency Circle Linthicum MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 19, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny injury or once. New Cathedral Cem. 2006 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 MO1357 Carl 23a. Part1. Ente Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ear /Medical Due to (or as a confequence of) Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a nonsequence off The law requires that the death certificate be executed -tran and Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 XYes been si 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s effer de... 1 Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours of 1x Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier voletely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 16, 2006 arkan\_M.D D39505 use of death (Item 23a) (Type, Print) 305 Hospital Dr. Glan Burnie, MD 2106/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) indhish man

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

	·		1 - For State Amend item#4c, 29 Registrar		d/Depa 10/17/06	artment of rtificate o	Health ar of Death			
	Physici /Media		Decedent's Name (First, Middle, Last)     JEAN	MILDRED	V	WARTZMAN	l	2. Date of Dea	ER <sup>Da</sup> 15, 2	3. Time of Death 8:42 P M
	Examir	er	4a. Fecility Name (If not institution, give s 6934 BLANCHE ROAD	)			BALTI	MORE	Baltimor	e <del>N/A</del>
	Funeral Director		5. Social Security Number 578-34-6324  Usual Residence of Decedent	7. Age (In yrs. 76		Months Da		8. Date of Birth	930	9. Birthplace (State or Foreign Country) D. C.
	e Marylend a-f ehow	ctor	MD BALTIN		ty, Town or Lo	TIMORE				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28	rai Director	10e. Street and Number 6934 BLANCHE ROAL	)		10f. Zip Cod	21215		10g. Citizen of Wi	nat Country? USA
9800	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importents: If Item 27 ie marked other then "netural", or Iteme 23a or 28a-f ehow amy Injury or other traumatic event, Ira Medical Examinar must be notified at anote.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🛣 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. WHITE
Baltimore, Maryland 21215-0036	d within 72 ha giene. Ir then "netu	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most o tired)	-	16b. Kind of Bus	GOVERNMENT
yland	2 should be filed and Mental Hygi Ie marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOSEPH		MORI	RIS	18. Mother's	Name (First, Middle,	Maiden Sumame MARY	SHER
e, Mar	l and 2 sho Health and Im 27 le mu her traumu		19a. Informant's Name/Relationship (Ty, MARK ALAN WARTZMAN	/ SON	6711	PARK H	EIGHTS A		- BALTI	MORE, MD 21215
timor	rt. Pages I rtment of P rtent: If ite njury or ot		20a. Method of Disposition  1 A Burial 2 Cremation 3 A 4 Donation 5 Other (Specify)	emoval from State ARL	INGTON		AMUNO 1	0/16/2006	BALTIM	ORE, MD
Ba	permit. Departm Importer any inju		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or compli	itter		8900 RE			PIKESVIL	LE, MD 21208
	Pnysician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.			•	mer on "	<b>6</b> 31,	Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	HN	502 71	<i>M</i>		
O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	aldeath 3□	⊒Ectopic pregna ⊒ Other (specify,			23d. Date Mont	of delivery h Day Year
rds, P.	quires that in signed by	þ	Part II. Other significant conditions cor	stributing to death but not res	sulting in the u	nderlying cause	given in Part I.			oute to the cause of death?
Division of Vital Records,		Completed						24a. Was a autop perfor	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 □ No
VIta	ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner?	ospitaf:				Death (Check only or		
on of	ding Ph h. After th funeral	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	f 28c. Ir	4 ☐ Nursi		ence 6 Other	
DIVIS	ial or Attencts setter death	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory, offi	Ce .	28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Al within 24 hours effer of To the Funeral Direction to the filled in by	edicai	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or in	h occurred at the vestigation, in m	e time, date and p y opinion, death	place, and due to the o occurred at the time, o	ause(s) and man late and place, ar	ner as stated. ad due to the cause(s)
	To the crimple	Σ	29b. Signature and fittle of certifier	Elessu.	Mo "		ense number	40.	29d. Date signed	(Month, Day, Year) 2006
10	7		30. Name and ad ress of person who co	mpleted cause of death (Iter	п 23а) (Тура,		RY CA.	IL DAIO	- 1	12116
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	made s				,

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** sician and burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician ate has been signed by the atte page 2 should be detached for ours after death.

leral Director: After this certificatilled in by the funeral director. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) min-0 1/12 031865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) contain street 20 6 821 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 DHMH 17 Rev 1/2001 **ORIGINAL** 

		1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He rtificate of De	alth and I eath	Re	g. No.	32866
Physic /Med		Decedent's Name (First, Middle, Las.	Freder	ick t	t. Are	end	2. Date of Death	25,2000	2 10 PM
Exam	iner	4a. Facility Name (If not institution, give Howard County Ger		ital	4b. City, Town, or Lo	ocation of Death Lumbia		4c. County of De	ath Nard
Funera Directo		133-10-0004	7. Age	(In yrs. last birthday) 88 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 25)	Year) 9. 8 1918 N	irthplace (State or Foreign Country) Iew Jersey
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard		10c. City, Town or Lo		umbia			10d. Inside City Limits 1 □ Yes 🏖 No
3e or 28	Funeral Director	10e. Street and Number 5400 Vantage Point	Road, #9	13	10f. Zip Code	044	10	Og. Citizen of What C	
s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I tem 27 Is marked other then "natural", or items 23e or 28e-f show other traumatic avent, the Medical Exerciper must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Was Decedeni E Armed Forces? NEW es 2 □ N If Yes, Give Year or Dates:	0	Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 💯 No	panic Origin? (S Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, hite, etc. White
within 72 ho Jiene. r then "natur The Medical J	Completed	15. Decedent's Edit (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5- 5+	(Give	dent's Usual Occupation kind of work done duri DO NOT use retired) Or, Organi	ring most of wor	king	U.S. GOVE	
lid be filed lental Hyg ked other	To Be C	17. Father's Name (First, Middle, Last) Frederick Arend			18		ne (First, Middle, M Holcomb	faiden Sumame)	
nd 2 should be strong the sund M 27 la mar r traumat		19a. Informant's Name/Relationship (T James Arend/son	ype, Print)		ng Address (Street and Hayledge C			City or Town, State Maryland	Zip Code) 21045
permit. Pages 1 end 2 Department of Health 3 Important: If Itam 27 is any Injury or other tra		20a. Method of Disposition  ★★Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,		1	sition (Name of natory or other place) OWS Cemete	rv 9/2	Date 2 8/2006	20c. Location - City o	or Town, State
permit. P Departme Importa- any Injur	É	21. Signature of Funeral Service Licens	7	22	. Name and Address	of Facility J	ohn M. Ta	aylor Fune	
Physiciar /Medica Examine	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in dealh)	a	the death. Do not en		such as cardiac			Approximate Interval Between Onset and Death
icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, I any, isating to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
To the Hospital or Attanding Physician: The law requires thet the death certification that hours after death.  To the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
uires thet n signed by Id be deta	<u>م</u>	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause given	in Part I.	1		to the cause of death?
The law require ate has been signage 2 should t	Completed	Renal Fail	ure				24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of
sician: certifica irector,	Be	25. Was case referred to medical examiner?	Hospital:		Other		th /Check only one	)	
iding Phy th. After this	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury al Work?		28d. Describe ho	nce 6 Other (Sp w injury occurred	ecity)
To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Inju- building, elc.	ry - At home, farm, str (Specify)			28f. Location (Str. City or Town,	eet and Number or I State)	Rural Route Number,
na Hospit 124 hours na Funera sletely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner state	f my knowledge, death examination and/or in- ed.	occurred at the time, vestigation, in my opini	date and place ion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	10		29c. License n			Date signed (Mon	
		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type,	Print)	let von	+ Pkini (	alundin	6, 2006 MD 21044
S Regis	tate	31. Date filed (Month, Day, Year)	A. RegisIra	r's Signature	T HITTER	a lo real	Truy	201011 1019	1000 2177

			For State Registrar		State of M	aryland /		rtment of H tificate of I		Mental Hy	/giene, Reg. No.	cuun	32867
	Physici		Decedent's Name (F     Maria	irst, Middle, Las a Bodnaru						2. Date of D Month Septem	Day		3. Time of Death  11:31 PM
1	/Medio Examir		4a. Facility Name (If no.					4b. City, Town, or	Location of Dea			County of Death	
Н	Exami		Shady Grove	Adventis	t Hospital			Rockvi	ille		M	ontgomery	
	Funeral Director		5. Social Security Number 220-36-971.	ber 6. S		e (In yrs. last b 78	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir				nplace (State or Foreign untry) kraine
	p .		Usual Residence of De			10. Cit. T.							
	aryla ehov	_		0b. County		10c. City, Tov	wn or Loc						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	98a-1	Director		Montgomer	У			Damascu	18				
	with ti	ā	10e. Street and Numbe					10f. Zip Code			10g. Citiz	zen of What Cou	untry?
	• 23	erai	11339 Kings	s Valley	Drive 12. Was Decedent	Suprio II S	12 14		0872	Canada Van as N		U.S.A.	ican Indian
5-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel" or iteme 23a or 28a-i ehow imatic event, the Madigal Exem har must be notified as	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4	_	Armed Forces?  1 Yes 2 X  If Yes, Give Year or Dates:		1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 \ No	Specify:	rto Rican, etc.)	1	Black, White  Specify:  Whi	e, etc.
Š	2 hou	ted	15.	. Decedent's Ed	ducation	168	a. Decede	ent's Usual Occupa	ation		16b. Kir	nd of Business/I	
215	hin 7 In 'n Med	Completed	(Specify of Elementary/Seconda	only highest gra	de completed) College (1-4or	5+)	life. D	and of work done of NOT use retired	during most of wi	orking			
2	od wit	ь Б	12	, ( )			Li	ibrary Tech	nician		Libra	ary of Co	ngress
2	al Hygie d other	Be (	17. Father's Name (First	st, Middle, Last)					18. Mother's Na	ame (First, Middle	e, Maiden	Sumame)	
N	should be ind Mental marked o umatic eve	2	Nicholas	Piech					Ann	a Chomyk			
ar	permit. Pages 1 end 2 should be Department of Heelth and Menta Important: If Item 27 is marked eny injury or other traumatic espice.	i s	19a. Informant's Name	Relationship (	Type, Print)	19	b. Mailing	Address (Street a	and Number or F	Rural Route Numi	ber, City or	Town, State, Z.	ip Code)
<u>~</u>	end eelth m 27 her tr		Nadia O. Da		ughter			Kings Vall					
Ö	of H	- 3	20a. Method of Disposit		Removal from State	20b. Place o	of Dispos ery, crem	ition (Name of atory or other plac	Θ)	Date	20c. Lo	cation - City or 1	Fown, State
Baltimore, Maryland 2121	Par ment		4 Donation 5	Other (Specif	1)	Ceda		ll Cemetery		2/2006	Sui	tland, Ma	ryland
<u>a</u>	Depart Import eny inj		21. Signature of Funera	al Service Licer	66	+.		Name and Addres		1 Home. In	3C.		
_	<b>₹</b> □ <b>= 9</b>		Nana	7 H.	Vec	- Lip		11800 New F	lampshire	Avenue, S:	ilver :	Spring, M	aryland 20904
			23a. Part1. Enter the c shock, or heart a	disease, or com liture. List only	plications that caused one cause on each li	d the death. Do ne.	not ente	r the mode of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	al	Cardiog	enic Shoo	ck						36 hours
1	/Medical Examiner		resulting in death)		Due to (or as	a consequence	of):						
	Lammer		Sequentially list condition any, leading to mine	ions,	0.	ial Infa		1					48 hours
	si ad	ine	ff any, leading to inime cause. Enter Underlyin Cause (Disease or inju	ng 4	Due to (or as	à consequence	oly.						
	and -tran	Examiner	that initiated events resulting in death) Last		C. Due to (or as	a consequence	of):						
60,	cien cien buria		-		000 10 (01 23	a consequence	01),						
68760	ificate be executed g physicien and ss the burial-transit	edicai			d								
		/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy						2d Data al dali	
Box	eath etten for u	Physician/M	23b. Was decedent pre in the past 12 more	nths?		2 Fetal deat		Ectopic pregnancy Other (specify)			2	3d. Date of deli-	Day Year
о. О.	by the de	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	0	9□ Unknown	t time or death	٧.	Ollier (specify)					
٠.	The law requires thet the death cert te has been signed by the ettending age 2 should be detached for use		Part II. Other significan	nt conditions o	ontributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Division of Vital Records,	uires sign d be	d by	Coronary	Artery D	isease					10	Yes 2	]No 3∏Pro	bably 4 \Unknown
Ö	w require been signature	Completed				· · · · · · · · · · · · · · · · · · ·				24a. Wa		24h Wara aut	opsy lindings available
Ř	he la e has ge 2	E D								auto		prior to co death?	ompletion of cause of
ā			25. Was case referred	to medical						1 Yes		1 🗆 Yes	2 No
5	sicia cert irect	o Be	examiner? 1 ☐ Yes 2 ☒ No	1	Hospital:	ent 2 🗆 ER/O	utnotiont	3□ DOA Othe		eath <i>Check only</i> Home 5 Res		CO# ** (C* **	2.3
ō	ding Phy h. After this funeral d	. To	27. Manner of Death		28a. Date of Inju	ıry 28b.	Time ol	28c. Injun	4 🗀 ivuising	28d. Describe			iny)
0	th: Afte	ē	1 XNatural 5 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da	y Year)	Injury		<br Yes 2 □ No				
13	if or Attending Physician: efter death. Director: After this certific d in by the funeral director.	fica	3 ☐ Suicide 6	Could not be	289. Place of In		arm, stre	et, factory, office					ral Route Number,
Š	s effe	Certification:	4  Homicide		building, et	c. (Specify)				City or 10	wn, State)		
	To the Hospitet or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai (	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the best niner: On the basis of and manner st	f examination a	e, death nd/or inve	occurred at the timestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To th To th comp	₹	29b. Signature and title	o ol certifier	)	_		29c. License	e number		29d. Date	signed (Month	. Day, Year)
			Asin	int/	mach			DGG	1444		Sept	rember 2	18,2006
	10		30. Name and address	of person who	1 2	leath (Item 23a)	(Type, P						
	, -				, 9901 Medic	al Center	Driv	ve, Rockvil	le, Maryl	and 20850			
	Sta	-	31. Date liled (Month, I		407	ar's Signature	10						
	Registr		U	T 0 3 2	UUD Marie	w dt	675	ule)					
DH	MH 17 Rev 1/2	001											

ORIGINAL

Year

2006

30

0120 4

Physician /Medical Examiner	
Funeral Director	

1 - For State Registrar

**JOYCE** 

**JACKSON** 

BAILEY

1	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o	or Location of Deat	h		ty of Deat	
	E		5. Social Security Number 6.	At the Lake Sex 7. Age (In yrs. 10	ast birthday)	If Under 1 Year	If Under 24 Hrs	B. Date of B	irth		hplace (State or Foreign
	Funeral Director		222-28-9166	1□ M 2 🛣 F 65	Yrs.	Months Days	Hours Min.	AUG 08	av. Year)	Co	VES, DE
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
	Maryla -f eho	tor	MARYLAND WICOMI								1 <b>X</b> Yes 2 □ No
	th the or 28e	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Co	ountry?
	ath wi	ral	4 EAST ELIZABET			2185			UNITI		
21215-0036	72 hours after death with the Maryland neturel', or Iteme 23a or 28e-f ehow disel Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		/as Decedent of F Yes, specify Cub ☐ Yes 2 X No	Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N o Rican, etc.)	o- 14. Ra Bl	ack, White	erican Indian, e, etc. ERICAN DIAN
5-0	72 hours "neturel"	eted	15. Decedent's E (Specify only highest gr		(Give k	ent's Usual Occup	during most of wo.	rking	16b. Kind of		
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire TOMIST/E	d) -		HEALTI	H CAF	RE.
	filed Hygi ther		17. Father's Name (First, Middle, Las.		THEBO	1011151/1	18. Mother's Nar	ne (First, Middle			
lan		To Be	PHILLIP AL	LEN JACKSON			MARY	ELDA	MORRIS	5	
Maryland	2 should and Men ie marke eumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numi	ber, City or Town	n, State, Z	Zip Code)
	127 E E		GARY BAILEY	(SON)			CT., LE			2065	
Baltimore,	0 0		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Special Contents)	Removal from State ISR	emetery, crem AEL UNI RCH CEN		H. OCT	Date 04,2006	LEWES	,	
Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lies	M0136	. W		ess of Facility  INERAL HO  DELAWA				
1	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death one cause on each line.	Do not ente	BOWEL	ng, such as cardia	or respiratory	arrest.		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of): RE	NAL FAD	LURE				
В	Examiner	er	Sequentially list conditions,	b. Due to (or as a consequ	UNA	021/	-				
	uted Insit	mlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (0) 23 2 00/13040	ierice ory.						
ó	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	C Due to (or as a consequ	ience of):						
68760,	at Kright	lcal	•	d							
	certific inding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				204.5		
O. Box	ne death the etter	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□	Ectopic pregnanc Other (specify) _	у		1	ate of deli Month	very Day Year
Δ.	s that the		Part II. Other significant conditions	contributing to death but not resu	ılting in the un	derlying cause gr	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
rds	w requires th been signed should be d	ed by						1 🗆	Yes 2 No	3 🗆 Pr	obably 4 Unknown
of Vital Records,	law re es be	Completed						24a. Wa	s an 24b	. Were au	itopsy findings available completion of cause of
E R	The la	Con							ormed?	death? 1 ☐ Yes	
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		On	26. Place of De				
	Phy this	. To	1 Tes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3□ DOA 28c. Inju Wo	4   Nursing F		how injury occu		cify)
ion	Attending I ir death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2 ☐ No				
Division	o the	Certification:	3 Suicide 6 Could not 4 Homicide determined		me, farm, stre	et, factory, office			(Street and Num own, State)	nber or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier to Certifying P (Check only one) 2 Madical Exa	hysician: To the best of my know minar: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time	a cause(s) and n	nanner as , and due	stated. to the cause(s)
	To the To the comp	Σ	29b. Signature and ittle of certifier	) Zaace		29c. Licen:	se number	>	29d. Date sign	ed (Monty	h, Day, Year)
_	BA 5		30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print) (VDA)	STAC	123	DICE.	RY	MD 2180
á	Sta Registi		31. Date filed (Month, Oay, Year) OCT 03 2	32 Aegistrar's Signat	4	de					

		-	For State Registrar	State of Maryl		partment of F			giene Reg. No.20	06	32869
			Decedent's Name (First, Middle, Last	)				2. Date of Dea		Year	3. Time of Death
	Physici /Medio		William L. Blade	s, Jr.				10		2006	0730M
Ž	Examin		4a. Facility Name (If not institution, give	street and number)	5 2	4b. City, Town, o	Location of Death	1	4c. County		
			pastal Hospic	e At the	Lake	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			ace (State or Foreign
	Funeral Director		5. Social Security Number 6. Se 219-62-9272	x 7. Age (//) 5	rs. last birthda Yrs.	Months Days	Hours Min.	Sept. 5	y, Year)	Count	1and
			Usual Residence of Decedent					Dept. J	, 1777		
	how in the w		10a. State 10b. County	10c.	City, Town or	Location				10	0d. Inside City Limits 1 1 Yes 2 □ No
:	8a-f	cto	DE Sussex		Laurel				10 000 (10		
:	Mith th	듑	10e, Street and Number			10f. Zip Code			10g. Citizen of W		try?
	as 234	erai	109 West Street	12. Was Decedent Ever i	n U.S. 13	199 3. Was Decedent of H		pecify Yes or No	U.S.A 14. Race	e - America	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1  ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rićan, etc.)	Specify	k, White, e	ite
ဝို	72 ho	ted	15. Decedent's Edi		16a. Dec	cedent's Usual Occup	ation during most of wor	kina	16b. Kind of Bu	siness/Ind	lustry
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done . DO NOT use retired		9		~	
7	ygien ygien her th	ပ်	47 February Mines Middle (1948)	3	Comp	uter Progr		o /First Middle	County  Maiden Sumam		ernment
and	ntal H	Be	17. Father's Name (First, Middle, Last)	- 0					Maioeri Sumam	9)	
Maryland	hould d Me mark matic	ပ္	William L. Blade  19a. Informant's Name/Relationship (7	-	19b. Ma	iling Address (Street		a Zinn ral Route Numbe	er, City or Town,	State, Zip	Code)
<u>8</u>	od 2 s Ith an 27 is r trau	13	Dawn O. Blades	(Wife)		9 West Str		Laurel,			
ē,	s 1 ar		20a. Method of Disposition		b. Place of Dis	position (Name of rematory or other place		Date	20c. Location -	City or Tov	wn, State
Ë	Page nent c int: if		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify		-	Hill Cemet	- F	5,2006	Laurel,	Dela	aware
Baltimore,	permit. Depertnimports mports any inju		21. Signature of Funeral Service Licen	600		22. Name and Addre					
	20 E # 9		x+, gwest	7		13 E. Grov	e St. D				
			23a. Part1. Enter the disease, or course shock, or heart failure. List only of	lications that caused the cone cause on each line.	death. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. BLA		C CA	NCERE	-260	DANGE	205	
	Examiner			Due to (or as a con	nsequence of):	310					
	38	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	isequence of):	21.5					
	outed id ansit	Examin	Cause (Disease or injury that initiated events	c.							
Ö,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a con	sequence of):						
	sate b	dicai		d							
Вох 68	w requires that the death certifica been signed by the ettending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		3 ⊟Ectopic pregnanc				e of delive	•
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown		5 Other (specify)	y		Moi	nth	Day Year
P. 0.	The law requires that the ste hes been signed by th bege 2 should be detache	P.	9 Unknown				on in Day I	22a Did t	obacco uso cont	ribute to th	e cause of death?
S,	res the signed	ð	Part II. Other significant conditions or	onthouting to death out not	t resulting in the	underlying cause giv	en in Part I.	1 🗆 '	Arm	3 ☐ Proba	<u>_</u>
Record	need should	Completed						1000	/		
ခိုင	48 88 64	mpi						24a. Was autor perfo	osy p	prior to com death?	osy findings available apletion of cause of
		e Co	25. Was case referred to medical				OC Plans of Day	1 Yes	A	Yes	2 No
Vital		To Be	examiner?	Hospital: Inpatient	2 ER/Outpat	ient 3□ DOA Ott	ner-	ath <i>(Check only c</i> Iome 5□ Resi	dence 6 □Oth	er (Specify	1)
0	g Phys er this eral di		27. Manner of Death	28a. Dat of Injury (Month, Day Yea	28b. Time	of 28c. Injur			how injury occurr		,
Ö	Attending r death. sctor: After by the fune	atio	1		injur		Yes 2 □ No				
É	al or Atte s after de ni Directo od in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, pecify)	street, factory, office		28f. Location (: City or To	Street and Numb wn, State)	er or Rural	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (		ysician: To the best of my iner: On the basis of exal and manner stated.							
	To the Comp	Σ	29b. Signature and title of certifier	. Jane		29c. Licens	se number > / 4 > \$	6	29d. Date signed	1 (Month, L	Oay, Year)
	2		30 Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print) COA	STAZ	14057	ICE AT	1-17	HE LAKE
	14		JAMES ISAA	es TE	ERS,	HEXT	SALI	SBUR	24/197	$\geq 2$	2180/
	St Regist	ate	31. Date filed (Month, Day, Year)  OCT 0 3	32. Registrar's S	Signature						,
ULI	MH 17 Rev 1/2	_	001 03 /	July player	S.	gozale					
DHI	17 116V 1/2	-001			ORI	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Trem 5 per Th 9862 12-12-06 vt.

State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 6 1. Decedent's Name (First, Middle, Last) 2 Date of Death September Da **Physician** 6:12A M В. Butler George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 579jal Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. <del>577</del>-56-3447 31, 1944 Washington, DC Director 61 Dec. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show troumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 7216 East Forest Road 20785 USA Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married ŏ 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Pvt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mentai marked 2 Joseph Butler Agnes Thomas Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7216 East Forest Road
Hyattsville, MD 20785 and 19a. Informant's Name/Relationship (Type, Print) item 27 LaVerne Butler/Wife other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 9/30/06 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funera Service Licenses 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, N.W., Was 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 716 Kennedy Street, N.W., Washington, DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final andus resperatory Physician Hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sertic nock Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner anding physicien and use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed bstruct Due to (or as a consequence of) Box 68760. Months attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 X No page 2 s rmed? 2X No 2X No certificete 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 DaInpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Directo letely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide LX Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Contilior To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD 58976 20-45-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calaf 20770 P.O. BOX297 Greenbelt, mb. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State OCT 0 4 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 26 **Physician** Shirley A. Batchelor 2006 2:29 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Yrs. 59 03/14/1947 Wash., Director DC 213-46-8723 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Hygiene. other than "natural", or tleme 23a or 28a-f show vent, I'ra Medical Examinar must be notified at 1X Yes 2 □ No Maryland | Prince George's Temple Hills Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 United States 5816 Temple Hills Road death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 📉 No f Yes, Give fear or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: Š 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fitteent of Health and Mental H tent: If Item 27 is marked ot Annie M. Holt Clarance C. Allen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5816 Temple Hills Rd., Temple Hills, MD Constantina Batchelor/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any Injury or once. Lee's Crematory 10/6/2006 Clinton, MD 21. Signature of Fulleral Service License 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE, ARTHEROSCLEROTIC 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ARDIOVAS CULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTENSION 2 🗆 No 1 ☐ Yes 2 🖪 No 1 Yes 25. Was case referred to medical examiner? eral Director: After this certific filled in by the funeral director. Certification: To Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09-26-2000 D52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 CENTRAL AV #301, LANDOVER MD 20785 MUSA MOMOH MD

State Registrar 31. Date filed (Month, Day, Year) OCT 0 4 2006 32. Registrar's Signature

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate o	f Death	Reg. No. 2006 32873
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Month	of Death S. Time of Beath Pember 25, 2006 1205 hrs
- Zamino	Curcis Baccheror	4b. City, Town, or Location of Death	4c. County of Death
	5816 Temple Hill Road	Temple Hill	Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign
Director	578-64-3233 1 XM 2 F 60 Yr	Months Days Hours Min.	/01/1946 Country Wash., DC
, n	Usual Residence of Decedent		
ow any	10a. State 10b. County 10c. City, Town or Loca	tion	10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once. ector	Maryland Prince George's	Temple Hills 10f, Zip Code	10g Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once	5816 Temple Hills Road	20748	
with the 23a se noti		as Decedent of Hispanic Origin? (Specify Yes	United States or No- 14 Race - American Indian, Black,
r death with or items 23. must be no Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No	Yes, specify Cuban, Mexican, Puerto Rican, etc	C.) White, etc.
safter rral", o nimer r	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	Specify: Black
hours matur Exam	during o	nt's Usual Occupation (Give kind of work done nost of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th	Floorman	Destrocto
d with signature of the record	17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Mi	Private  ddle, Maiden Surname)
11215-0036 Id be filed within 72 hours after dental Hygiene narked other than "natural", event, the Medical Examiner o Be Completed by	Vernon Batchelor		Hazel Jackson
D 21 hould hould Me is ma utic ev		g Address (Street and Number or Rural Rout	
MD 2 and 2 shou lealth and N tem 27 is n traumatic		Temple Hills Rd., To	emple Hills, MD 20748  20c Location - City or Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f short or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 Removal from State crematory or o	ther place)	
- E 2 0		Crematory 10/6/20 Name and Address of Facility Stewart	
Balt permit Depart Impor	21 Signature of Funeral Service Incensee	4001 Benning Rd., NE	rt Funeral Home
Physician	233) art I. Enter the disease, or complications that You et The death. Do not enter		ory arrest, shock, or heart Approximate Interval
/Medical	thilure. List only one cause on each line.  Immonate Cause (Final disease a Atherosclerotic Cardiovascular Dis	sease	Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):		
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
i i	cause. Enter Underlying Cause (Disease or injury that initiated		
ted ansit Examiner	events resulting in death) Last Due to (or as a consequence of):		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit endical Certification: To Be Completed by Physician/Medical Exi	d. UNPENDED AMENDED		
760, ficate be g physici the buri	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
6876 ertificat ding phy e as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fig. 1	etal death 3 Ectopic pregnancy	Month Day Year
P.O. Box 68 that the death certify need by the attending detached for use as by Physician	1 Yes 2 No 9 Unknown Pregnant at time of death 5 O	ther (Specify)	
D. E at the d by the ached	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death?
rres that signed I be deta	Seizure Disorder; Chronic Alcoholism	1[	Yes 2 No 3 Probably 4 🗸 Unknown
Records, The law requires fricate has been sig page 2 should be Completed		24a.	Was an 24b. Were autopsy findings available prior to completion of cause of
eco he lav ate has age 2 :		1	performed? death? Yes 2 No 1 Yes 2 No
ital Recionar: The conficate lector, page	25. Was case referred to medical	26 Place of Death (Check only one)	
f Vit; Physici er this c ral direc	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		5 Residence 6 Other Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rapler death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	27. Manner of Death 1 Natural 5 Pooding (Month, Day, Year) 28b. Time of		scribe how injury occurred
Division o Spital or Attending squital or Attending tours after death meral Director: Aft filled in by the fune Certification:	2 Accident Investigation	1 Yes 2 No	
Divi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre		ation (Street and Number or Rural Route Number, City own, State)
Hospii 14 hour Funer ely fill	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the control of the cont	irred at the time, date and place, and due to the	e cause(s) and manner as started
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E	one) 2 Medical Examiner; On the basis of examination and/or investigation and manner stated		1.1
E S E S O	29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Hatullonia-Hollohm	O.C.M.E.	September 26, 2006
nit of	30. Name and address of person who completed cause of death (Item 23a)	444 Donn Charat Dallinson 140 (	24204
All	Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date fled (Month, Day, Year) C 32. Registrar's Agnature	111 Penn Street, Baltimore, MD 2	21201
State Registra			

			1 - For State Registrar	State of Ma	aryland		artmen tificat				R	eg. No.	006	32873
	Physici	an	Decedent's Name (First, Middle, Las     Pedro	t) A •		Bay1	.on				2. Date of Dea Ctober		006 <sup>Year</sup>	3. Time of Death 12:07 Ам
	/Medic Examin		4a. Facility Name (If not institution, give			J		Town, or	Location o				ounty of Death	
			University of Mar				If Under		imore		a Day of Birth		0.000	/6****
	Funeral Director		5. Social Security Number 6. Se 11 224-52-1677	ETM OFF	e (in yrs. ia 33	st birthday) Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Day April 14	Year) 1923	9. Birti Co. Phi	pplace (State or Foreign intry) ippines
	D		Usual Residence of Decedent  10a. State 10b. County			Town or Lo	cation					,		10d. Inside City Limits
	Maryla -f sho	tor	Maryland Charles			dorf	Oution							1 ☐ Yes 2XXNo
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code				0g. Citize	n of What Co	untry?
	s 23a	ral	4061 Cottontop Court					20603			7	1 44	USA	
_	fter de r ftem frer r	Fune	11. Marital Status 1 ☐ Never Married 25 Married	12. Was Decedent I Amed Forces? 1 XYes 2 □ N		45-1				gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	İ	Black, White	e, etc.
9500-612	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "natural", or items 23s or 28s-f show event, Ite Medical Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1975		1 □ Yes	2KKNo	Specify:			St	pecify: Fil	.1p1no
ភ្ន	within 72 h ene. then "natu	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Deced (Give life.	dent's Usu kind of wo	al Occupa rk done d se retired,	ition <i>uring m</i> ost )	of workin	ng	16b. Kind	ol Business/l	ndustry
_	d with giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	U.S.							Militar	У
yland	be filed v ntal Hygie od other t	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle, silia A	Maiden Su Juino	imame)	
	d 2 should th and Men 7 is marke treumatic	ဥ	Damaso Baylon  19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailir	ng Address	(Street a	nd Numbe		Route Number	*	own, State, Z	ip Code)
, Mar	Te T		Esperanza M. Baylo	n / Wife		4061	L Cot	tontop	Court	t Wald	lorf, Mar	yland	20603	
baltimore,	Pages 1 end nent of Healt int: if item 2 iry or other i		20a. Method of Disposition   ↑   ©XBurial 2 ☐ Cremation 3 ☐		Cer	ace of Dispo metery, crer	natory or o	other place			ate		tion - City or	
			4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen.		Arlı	ngton l			s of Facilit	10/30/			ton, Vii	
ñ	Departition Depart		Sur P. Ka	la f		İ				GE	orge P. 1 Hill, M			
1/60,	Physician /Medical /M	ilcal Examiner	23a. Part1 Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  Due to (or as  Due to (or as  Due to (or as	a conseque	E(PV)	inn atio	400	arhy 748C	r A V d	ial In	farci	t-Ca-	Approximate Interval Between Onset and Death
	it the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	Ectopic p					230	f. Date of deli Month	very Day Year
, T	w requires that the been signed by the should be detached	þ	Part II. Other significant conditions of		46.5		_	ause give	n in Part I.					the cause of death?
ecord		eted	Chronic Ker	al Jose	14416	180 C	7				-	es 2 🗆 l		obably 4 Unknown
1	sician: The law certificete has b rector, page 2 st	Completed				-					24a. Was a autop: perfor	SV		topsy lindings available ompletion of cause of 2 No
	ysician: is certifice director, p	Bec	25. Was case referred to medical examiner?							ol Death	1 ☐ Yes (Check only or		10 163	2010
ō	Phy this rat di	. To	1 Yes 2 No	Hospital: 1 Inpatie	iry 2	R/Outpatier		Othe 28c. Injury	4 🗆 140		ne 5 ☐ Resid			afy)
0	Attending F r death. ector: After by the funera	atlor	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	ý Year)	Injury	м	Work	? ∕es 2 🗆 l			,		
=	in the of	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	ne, farm, str	eet, lactor	y, office		2	81. Location (S City or Tow		lumber or Ru	ral Route Number,
	ne Hospital 124 hours a ne Funeral Hetely filled	Medical	29a. Certifier   1 Ty Certifying Phy (Check only one)   2 Medical Exam	ysician: To the best on the basis of and manner sta	ol my know f examination	rledge, death on and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	nd due to the d id at the time, o	ause(s) an late and pl	d manner as ace, and due	stated. to the cause(s)
	To the I within 2 To the I complet	₩e	29b. Signature and title of certifier					c. License					igned (Month	
	10		1 Teller			·····		0190	94		(	187.	2, 2	286
	3		30. Name and address of person who	completed cause of d	leath (Item :	23a) (Type,	Print)	د ام م	CT D	-	Paltin	260-	10 2	1201
199	Sta		31. Date liled (Month, Day, Year) OCT 0 4 2086	32. Registra	ar's Signatu	THE PARTY OF THE P	Gre	J'C	21100		Ra/Tim	1	7/	~ "/
	Registr	ar	OUL A 4 FORD	And had	6									

DHMH 17 Rev 1/2001 . . .

			1 - For Stata Registrar	State o	f Mary	land / Depa <i>Ce</i>	artment of interes	Health and <i>Death</i>		ien@ () () 6	32874
	Physici		1. Decedent's Name (First, Middle, Alice Bel	•					2. Date of Deal Month	h Day Year 30 2000	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, University of Maryla			es		or Location of Dea	ath	4c. County of Dear	h
	Funeral Director		245-34-5252	.Sex 1□M 2∏ F	7. Age (In 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days			9. Bin 5 1925 WES	hplace (State or Foreign untry) \(\times \text{VIRGINIA}\)
	death with the Maryland ma 23a or 28a-f ahow r must be notified at	tor	Usual Residence of Decedent	GEORGE'		c. City, Town or Lo					10d. tnside City Limits 1  Yes 2 No
	23a or 28	Funeral Director	10e. Street and Number 12711 WHITEHOLM	DRIVE			10f. Zip Code 20774		1	Og. Citizen of What Co	ountry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Any injury or other traumatic avant, the Medical Examination must be usefiled at any injury or other traumatic avant, the Medical Examination must be usefiled at any injury.	þ	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deci Armed Fo 1 Tes If Yes, Gin Year or D	rces? 2 ∐NNo ⁄e		Was Decedent of If Yes, specify Cult		(Specify Yes or No- arto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
200-612	hio 72 ho e. no natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) Coltege (1	-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w d)	rorking	16b. Kind of Business	Industry
4	led wil lygien her tha		12th			NU	RSES AID		(5)	PRIVATE	
<u>a</u>	d be fi	Be C	17. Father's Name (First, Middle, La JESSIE RHINE						ame (First, Middle, I INY DULIN	Maiden Sumame)	
Maly	nd 2 shoul elth and Me 27 ie mark r traumati	ပို	19a. Informant's Name/Relationship			19b. Mailir 12711	ng Address (Stree WHITHOL	t and Number or I	Rural Route Number UPPER MAR	City or Town, State, 2 LBORO, MARY	Ep Code) LAND 20774
alumore,	Pages 1 a ment of Hee mnt: if itam ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	ob. Place of Dispo cemetery, crer RIVERDALE		- 1		20c. Location · City or RIVERDALE,	
a d	permit. Departr importr any init		21. Signature of Funerat Service Li	censee	10		Name and Addr 7474 LANI			CINS FUNERA	
~ . F	Physician		23a. Part1, Enter the disease, or a shock, or heart failure. List or tmmediate Cause (Final disease or condition		aused the lach line.		er the mode of dy	ing, such as cardi	ac or respiratory arre	est,	Approximate Intervat Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a cor	nsequence of):					
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	trial our	fi brilleti	en				
	ecuted ind transit	amir	Cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last		in ter						
,0070	cate be exected and the burial-	dical Examiner	resolding in death, cast	-	o as a cor	nsequence of):					
0.00	Ine law requires that the death certilicale be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown		inth 2 🔲	Fetat death 3	Ectopic pregnand Other (specify)	ey .		23d. Date of del Month	ivery Day Year
cords, r	urres that signed b Id be deta	by	Part II. Dther significant condition	contributing to de	ath but not	t resulting in the u	nderlying cause g	ven in Part I.		pacco use contribute to	the cause of death?
1000	Pnysician: The law req this certificete has beer al director, page 2 shou	Completed							24a. Was al autops perform	y prior to oned? death?	topsy findings available completion of cause of
		Bec	25. Was case referred to medical examiner?	11 31					eath (Check only on		
	Physician: rthis certific ral director.	<u>-</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1		2 ER/Outpatier	IL 3LI DOA			nce 6 Other (Spewintury occurred	cify)
NISION :	Attending ir death. ector: After by the funer	ation	1 Naturat 5 ☐ Pending 2 ☐ Accident investiga		h, Day Yea	ir) Injury	Wo	ork?` ]Yes 2□No	250. 2036/100 //0	w injury cocurred	
	tel or Atters after de mi Directo ed in by ti	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place	of Injury - , ng, etc. (Sp	At home, farm, str oecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	uith to the Hospitel or Attending Fin within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier 1  Certifying (Check only 2 Medical Ex	aminer: On the ba	best of my asis of exam ner stated.	knowledge, death mination and/or in-	n occurred at the t vestigation, in my	me, date and place opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	with of the company o	Σ	29b. Signature and title of certifier	The -	T. le	90		se number 9758	21	9d. Date signed (Monti	
	Co		30. Name and address of person who was South Green S		e of death		Print) The	epontment	of Anes Ke	ni oboqu	

DHMH 17 Rev 1/2001

State Registrar

Robert Anthony Bennett

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 32875

		1-For State Registrar		Ce	ertificate	of	Death				Reg. N			1 00	201
Physicia	an/	1. Decedent's Name (First, Midd	le Last)						2	Date of De Month	ath Day	/ Yea		3. Time of D	
ledical Exami	ner	Robert Anth								October	9, 20	06		0950 hi	rs
		4a. Facility Name (if not institution 425 East Main Street	on, give street and n	umber)		4	b. City, Town, or Lo Westminster	ocation of	Death			4c. County o	of Death		
			6. Sex	7. Age (In yrs.	loot hinth do		If Under 1 Year	If Under	Odlica	P Data of F	irth (A a)		J O Pust	nines (Ctots	
Funeral Director		5. Social Security Number				}	Months Days	Hours	Min.			M/DD/YYYY	Foreign	1	
Director		213-68-5076	1 X M 2 F		50	Yrs.				Oct 2	24 ]	.955	Cou	ntry) F	la
<u> </u>	ŀ	Usual Residence of Decedent  10a. State 10b. County		Ino Cit	y, Town or Lo	ocatio	n .							10d. Inside (	City Limite
ow any														1 Yes	- 1
Maryland 28a-f show 1 at once.	ğ	MD Carre	211		Westmi	ns		_			10.0		بليب	2.5	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number					10f. Zip Code				TUG C	itizen of Wh	at Count	луг	
th the 333 or	의	425 East Main					211.	<del></del>				USA			
th wi	Je l	11. Marital Status  1 Never Married 2 M	arried Armed F	cedent Ever in I Forces?			Decedent of Hispa es, specify Cuban, I				10-	14 Race White		an Indian, B	lack,
or dea	Funeral		1 Yes	2 🔀 No			V 2 -N-					0	r.	1h i to	
hours afte 'natural''; Examine	ā	3 Widowed 4 Div	or Dates:			_	Yes 2 XNo		nd of wo	rk done	116h	Specify: Kind of Bus		hite	
5-0036 ed within 72 hours a tygiene. other than "natura"	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)			st of working life. I				1.02	Auto of Bar	0111000711	duodiy	
5-0036 led within 72 Hygiene. other than '	롈	12		, , , , ,			Disable	đ				N	<b>/</b> A		
5-0036 iled within 7 Hygiene.	팃	17. Father's Name (First, Middle	, Łast)				18	B Mother's	Name (I	First, Middle	, Maide	n Surname)			
21215 uld be file Mental H marked c	Be (	Timothy Conrac	1 Bennett				Ι,	Patsv	7 Tel	Baron					
e, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumarite event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations	ship (Type, Print)		19b. <b>M</b> a	iling	Address (Street				umber,	City or Towi	n, State,	Zip Code)	
MD and 2 sho at 27 is aumati		John Bennett/	Brother		92	G	rand Driv	ve I	ane	town.	MI	217	87		
ore, MEss land 2 s of Health au If item 27		20a. Method of Disposition  1 XBurial 2 Cremation	n 3 Removal		Place of Dis		tion (Name of ceme er place)	etery,		Date	200	c. Location -	City or T	own, State	
Baltimore, N permit Pages I and Department of Healt Important: If item injury or other trau		4 Donation 5 Other S					ge Cemete	3777	10/1	12/200	ما	Elleria	300	MD	
altin mit portm		21 Signature of Funeral Service		1 1.1			Ters of the							11117	
ii ii ii ii ii ii ii ii ii ii ii ii ii	ı	John K And					2 Washin							21.	157
Physician		23a Part I. Enter the disease, or failure. List only one cause	e on each line	caused the deat										Approxima Between (	
.Medical Examiner	- 1	Immediate Cause (Final disease		ensive ath	neroscle	rot	cic cardiov	ascula	ar di	sease					ath
Adminer		or condition resulting in death)	Due to (or as	a consequence	of):										
` .		Sequentially list conditions,	b		. 6								_		
	ij	if any, leading to immediate cause. Enter Underlying Cause		a consequence	OI).										
	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence	of):										
ecuted and transit			d												
760, cate be ev physician he burial	gi	X UNPENDED	AMENDED	#23a,27,p	erÆ,g8	60,	10/26/06	TT							
8760, tificate be en an physician as the burial	n/Medical	IF FEMALE: 23b. Was decedent pregnant in t	23c, If yes	, outcome of pre	gnancy						2	23d Date of			
certif	iar	past 12 months?	I Live	ισιπη Inant at time of α	death 5		_	Ectopic	oregnand	су		Month	Da	àУ	Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Un	known	nown	3	Oth	ner (Specify)								
. ž \ ž		Part II. Other significant condi	tions contributing	to death but not	resulting in t	he ur	nderlying cause giv	en in Part	: I.	23e. Did	tobacc	o use contri	bute to the	ne cause of	death?
P.O. es that the igned by be detac	d b									1Y	es 2	No 3	Proba	ably 4 🗸 l	Jnknown
ds requir	ompleted			,		_				24a. Wa				opsy findings	
COI e law e bas l	m d	-			· · · · · · · · · · · · · · · · · · ·					per	opsy formed	? d	eath?	mpletion of	
Re : The ifficate	ပ	25. Was case referred to medical				_	26.Place o	of Dooth /	`hook or	1 Yes	2	No 1	Yes	2	No
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been sied in by the funeral director, page 2 should t	Be	examiner?	Hospital.	Inpatient 2	ER/Outpat	ient		thos:		Home 5	Resi	dence 6	Other	Scene	
n of V ding Phy After thi funeral d	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time							njury occurre		000110	
nding th.	io.	1 Notinel	(Mon	th, Day, Year)			1 Ye	s 2	No l						
isior Attend rector: by the	icat		estigation 28e. Pla	ace of Injury - At	home, farm,	stree	t, factory, office bu	ildina, etc.	2	8f. Location	(Stree	t and Numbe	er or Rur	al Route Nur	mber, City
Divi	Certification:		ild not be sermined (Specify		, ,			J,		or Town					
lospii 4 hou iumer		29a. Certifier	Physician: To the be	est of my knowle	dae death o	CCLEE	red at the time, date	e and nlac	e and d	ue to the ca	use(s)	and manner	as starte	ad .	
Di To the Hospital within 24 hours To the Funeral	Medical	(Oncon only	aminer: On the basis	of examination	-										
5 × 5 0	Š	29b. Signature and title of certifi	and manner er	stated.			29c. License	number			290	d. Date signe	ed (Mon	th, Day, Year	)
		1/1	11/6 1	7-4			O.C.M	1.E.			0	ctober 10	, 2006		
MAY		30. ame and address of person	n who completed a	use of death (Ite	m 23a)						_L_		-		
Ø	d d	Theodore M. King, Jr		tant Medical		r	111 Penn Stre	et, Balt	imore,	MD 212	01				
	tate	31. Date filed (Month, Day, Year,		egistrar's Signa	ature	,									
Regis		OCT 11	2006	dur 1	K 1	264	W								
DHMH 17 Rev 1/2	2001		•		ORIGI	NAL									

			1 - For State Registrar	State of M	aryland /		rtment tificate			and Me		giene Reg. No.	006	3287	16
5.	Physici		1. Decedent's Name (First, Middle, L	,							2. Date of Dea Month	Day	Year	3. Time of De	eath M
1	/Medi Examir		William August  4a. Facility Name (If not institution, g		)		4b. City, 1	Town, or	Location o		Septemb	1	29 2006 County of Dea		
			Carroll Hospita						inste				Carro	11	
**	Funeral Director		5. Social Security Number 6.  217-12-1558  Usual Residence of Decedent	Sex 7. Aq 1½∏ M 2 ☐ F	ge (In yrs. last I	Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Day Feb 02	y, Year)	C	thplace (State or Foountry)  MD	oreign
	yland		10a. State 10b. County		10c. City, To	own or Loc	cation							10d. Inside City L	imits
	e Mar	ctor	MD Carro	11		Westr	ninst	er						1 XYes 2[	□No
	vith th	Dire	10e. Street and Number				10f. Zip						en of What C	ountry?	
	s 23s	era	469 East Green	Street 12. Was Decedent	Ever in II S	13 \		2115	·	nin? /Cno	of v Voc or No		JSA 4. Race - Ame	niona Indian	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mentat Hygiene. If Item 27 is marked othar then "natural", or Items 23a or 28a-f show or othar traumatic event, the Medical Examinar must be rooffled at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	?		Yes, spec		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		Black, Whi		
5-0036	72 hou	Completed	15. Decedent's (Specify only highest of	Education		Sa. Deced	ent's Usual	l Occupa	tion	of workin	a l	16b. Kin	d of Business	/industry	
2121	within ene.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	OO NOT us	e retired)		Or WOTKIT	9		's Cra	b	
42	filed v Hygie other t		7 17. Father's Name (First, Middle, Las	st)		_ Owr	ner/O	_		r's Name	(First, Middle,	Hous			
/lan	should be find Mental I	To Be	William A. Blum								tford		samamo <sub>j</sub>		
Maryland	12 sho h and h 7 is ma trauma		19a. Informant's Name/Relationship Denise Mitchell/		15						Route Numbe				
	s 1 and f Health Item 27 othar ti		20a. Method of Disposition		20b. Place	of Dispos		e of			ate		ation - City or		
imo	Part tr		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			-	ter C			0/3/	2006	West	minste	r, MD	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr 2002.		21. Signature of Funeral Service Lic	Ze							and Ch Westr				
	Physician		23a. Pp. 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each I	d the death. Dine.	o not ente	r the mode	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	
8760,	Medical Examiner  ohysician and the purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence a consequence	enic		Hear	+ 0	Bea	se			10475	
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pre Other (spe					23	3d. Date of de Month	livery Day Year	r
rds, P.	quires that in signed b uld be deta	by	Part II. Other significant conditions	contributing to death t	out not resulting	in the un	derlying ca	iuse givei	n in Part I.			bacco us		the cause of death	
Vital Records,		Completed				-					24a. Was a autop. perfor	med?		utopsy findings avai completion of causi	
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							of Death	Check only or				
of	ding Phys h. After this funeral di	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	Hospital: 1 Anpati 28a. Date of Inju (Month, Da	ıry 28b	Outpatient Time of Injury		Bc. Injury Work	4 🗀 1401	28	e 5 Resid			cify)	
Division	irec irec	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of In	jury - At home, c. (Specify)	farm, stre	et, factory,	office		21	8f. Location (S City or Tow		Number or Ri	ural Route Number,	
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	edicai (	29a. Certifier 1 Certifying F 2 Medical Exa	thysician: To the best aminer: On the basis of and manner st	f examination a	ge, death and/or inve	occurred a estigation,	it the time in my opi	e, date and inion, deat	d place, ar h occurre	nd due to the d d at the time, d	ause(s) a late and p	nd manner as place, and due	s stated. e to the cause(s)	
)_	S S S S S S S S S S S S S S S S S S S	Me	29b. Signature and title of certifier	MO			29c.	License D 5	number 203	5	2	Sep	signed (Mont	n, Day, Year) ( 29 203	76
9	STICKE!		30. Name and address of person who	completed cause of c	death (Item 23a	Type, P	Print)	e	ent	ertm	insta		10 21	157	
.42	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 2 2	37/Registr	trey rar's Signature	Spa	de								

DHMH 17 Rev 1/2001

WILLIAM AdoUST BUM

			1 - For Stata Registrar	State of M	aryland / Dep <i>Ce</i>	artment of He <i>rtificate of D</i>	ealth and M <i>eath</i>		2º006	32877
			Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
	Physicia	_	Emma Belle BRAM	शास			1	Month Oct. 4	Day Year 2006	3:40 a.m. <sup>M</sup>
	/Medic Examin		4a. Fecility Name (If not institution, gr			4b. City, Town, or I	ocation of Death	0000	4c. County of De	
Н			Julia Manor Hea	Lth Care C	enter	Hagers	town		Washing	ton
	Funeral			Sex 7. Ag 1 ☐ M 2 【X]F	ge (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. B	irthplace (State or Foreign Country)
	Director		212-/4-3/33	ILIM ZUAF	92 Yrs.				1914 W	***
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary	ŏ	M1 1 111		77					1X Yes 2 □ No
	the 28a	Director	Maryland Washii 10e. Street and Number	igton	на (	10f. Zip Code		10g	. Citizen of What C	Country?
	3a or		11 W. Baltimore	Stroot		217	<i>/</i> .O		TICA	749
	death ms 2	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	panic Origin? (Spe	cify Yes or No-	USA 14. Race - Am	
21215-0036	within 72 hours after death with the Maryland jiene. r than "netural", or Items 23e or 28e-f show the Marical Examiner rout be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No	If Yes, specify Cuban  1 ☐ Yes 2 🖾 No	Specify:	Hican, etc.)	Specify: W	
2-0	72 ho	Completed	15. Decedent's 8 (Specify only highest g		16a. Dece	dent's Usual Occupat	ion uring most of workin	16	b. Kind of Busines	s/Industry
2	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	, and the second	.9		
	e filed within al Hygiene. other than vent, the Ma	S	12	0	I	lomemaker			ler own h	ome
and Pure		Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	2 should be and Mental Is marked aumatic ev	ဥ	Lewis Wayne Arno		405 14-11			zabeth H		7. 0-40
Mai	nd 2 statth and 27 is retraur		19a. Informant's Name/Relationship			ng Address (Street ar			•	
	1 a Head		Imogene B. Shank 20a. Method of Disposition	- Daugitte	20b. Place of Disp	.8 Clinton of Osition (Name of	D		oc. Location - City of	
Baltimore,			1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			matory or other place,	ŀ	'0 <i>(</i> 11		O. W. 1801 1
Ħ	# E E E	- 1	21. Signature of Funeral Service Lice			own Cremato 2. Name and Address		The second second	uneral H	n, Maryland
B	Depar Impo eny ir	1 0	1300 Q	Pauli	4	15 E. Wil:			town, Md	
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the death. Do not en	ter the mode of dying	such as cardiac or			Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	17	ronary	Arta	0	iscaso	2	Onset and Death
	/Medical		resulting in death)	a	a consequence of):		-			
	Examiner		Sequentially list conditions.	b		yor all	1			
	Si si	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consucial and all the					
	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
58760,	cate be executed physician and the burial-transit				2 331133 317.					
687		edical		d						
Вох	law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de	elivery Day Year
P.O.	w requires that the de been signed by the a should be detached f	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	t time of death 5	Other (specify)				
	s that ned b	by PI	Part II. Other significant conditions	contributing to death t	out not resulting in the u	inderlying cause giver	in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
of Vital Records,	quire an sig uld b		1ty Po	Myroidi	5-00			1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
00	aw re	Completed	Ata	rial Fi	brillati	0 1		24a. Was an	24b. Were a	autopsy findings available
ž	0 - 0	Ho						autopsy performe 1 ☐ Yes 2 ☑	d?   death?	
ita		Bec	25. Was case referred to medical examiner?				26. Place of Death			
<b>=</b>	Physicien: this certific al director,	0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie		4 Lanuising non	ne 5 🗆 Residend	ce 6 □Other (Sp	ecity)
ū	Attending Physicien: r death. ector. After this certific by the funeral director.	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o lay Year) Injury	Work?		8d. Describe how	injury occurred	
sio	tend leath tor: / the fi	cati	2 Accident investigate 3 Suicide 6 Could not				es 2 No	IDE I postion (Cton)	at a and Africa base on F	Rural Route Number,
Division	after dans in by	Certification:	4  Homicide determine	200. Place of In	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	2	City or Town, S		nural noute Number,
	spita lours neral filled	aic	29a. Certifier 1 Certifying P	hysicien: To the best	of my knowledge, deat	h occurred at the time	, date and place, a	nd due to the caus	se(s) and manner a	as stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai			of examination and/or in					
	To the To the Comp	M	29b. Signature and title of certifier	1 A		29c. License		29d	. Date signed (Mor	
•			I famil m	السمار		100	6039	L	10 04	100
3H	-1		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print) 11 2	6 oral	down	ND J	1740
	Sta	_	31. Date filed (Month, Day, Year)  OCT 0 5		rar's Signature	1	J	,		
	Registr		# # # # # # # # # # # # # # # # # # #	Z DEBO 1 25.	Ra A	4.07				

			1- Stata Registrar WCHD/SH 1	8 State of M 0/5/06 per	laryland FH	/ Depa	artment of F tificate of	lealth and Death	Mental Hy	giene (	006	32878
			Decedent's Name (First, Middle, )						2. Date of Dea	ath		3. Time of Death
	Physici /Medi		Kenneth Earl BR	ASHEARS					October	Day	2006	11:00 PM
	Examir		4a. Facility Name (If not institution, g	rive street and number	r)		4b. City, Town, o	r Location of Dea		7	unty of Death	1
			Washington Coun	tv Hospita	1		Hagers	stown		Wash	ningtor	n
	Funeral		Social Security Number 6		ge (In yrs. las	,,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h	9. Birth	place (State or Foreign
	Director		214-30-1742	145 M 20 F	74	Yrs.			July 2	1 1932	2 Ma	aryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					10d. Inside City Limits
	Manyl f ehc	ō	M11 II II -1									tX Yes 2 □ No
	the 28s	Director	Maryland Washin  10e. Street and Number	gton		Hager	10f. Zip Code			10a Citizen	of What Cou	untru?
	3a or	0	610 II Franklide	Channah			2174	/. O		USA		
	death	Funeral	610 W. Franklin	12. Was Deceden			Vas Decedent of H	ispanic Origin? (\$	Specify Yes or No-		Race - Ameri	ican Indian,
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercities must be notified at ADGs.	by Fur	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	] No	1	Yes, specify Cuba	n, Mexican, Puer Specify:	to Rican, etc.)		Black, White, ecify:	
21215-0036	tura F	ed	15. Decedent's	Year or Dates			ent's Usual Occup	ation		16h Kind d	of Business/Ir	White
15	n n	Completed	(Specify only highest	rade completed)		(Give i	kind of work done of NOT use retired	during most of wo	nrking	TOD. KING C	JI DUSIII <del>U</del> SSII	luustry
212	d with	E	Elementary/Secondary (0-12)	College (1-4or	(5+)	Repa	ir Tech.			City	Gove	rnment
פַ	othe	Bec	17. Father's Name (First, Middle, La	st)					me (First, Middle,	Maiden Sur	пате)	
<u>lar</u>	Alenta Alenta rked rked	To E	Kenneth Lee Bra	shears				Clara L	ara Loui: <del>ouise Se</del>	se Hor <del>Iby-</del>	ner	
Maryland	and he ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street		ural Route Numbe		wn, State, Zij	o Code)
Σ	alth 27 I	1	Mary Brashears	- Wife		610	W. Frank	lin Stre	et, Hage:	rstowr	n, Md.	21740
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Domestal from State		e of Dispos	sition (Name of natory or other place		Date		on - City or T	
Ĕ	Pag nent ant: h		4 Donation 5 Other (Spe			ar Law	n Mem. P	ark 10/	6/06	Hamer:	stown	Maryland
ä	ppartr portr portr y in		21. Signature of Funeral Service Lic	ensee			Name and Address		Minnich :			
<u> </u>	80E # 8		Fred Lib	estal		4	15 E. Wil	lson Blv	d., Hage:	rstown	ı, Md.	21740
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the death. line.	Do not ente	er the mode of dyin	g, such as cardia	c or respiratory are	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PM	eamo	win						Onset and Death
	/Medical Examiner		resulting in death)		s a consequer	1 1 10		-				
	Examine		Sequentially list conditions,	b. De	ment	19						17
	ed sit	line	r any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o. a.	s a consequel	nce on.						- > (
	and and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequer	nce of):				_		2,8
58760,	ficate be executed physicien and is the burial-transit	aiE		`								
289	ficate p phy s the	edicai		d								
Вох	eath certific attending p I for use as I	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of delive	arv
	The law requires thet the death certif Ite hes been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)				Month	Day Year
O.	t the by th	hys	9 Unknown	9□ Unknown								
	res thet the de signed by the a be detached f	by P	Part II. Other significant conditions	contributing to death	but not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use c	contribute to t	he cause of death?
<u>5</u>	w require been significant								1 ☐ Y	es 2□No	o 3∏Prot	oabiy 4 Qunknown
Records,	law re es be 2 sh	Completed							24a. Was a		b. Were auto	ppsy findings available
Ĭ.		ĕ							autops perfor	med? 2 No	death?	mpletion of cause of
<u> </u>	iiclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Ve		- ***	26. Place of Dea	ath Check only or			
<u>&gt;</u>	Physicis this cert al direct	ဥ	1 ☐ Yes 2∰ No	Hospital:		VOutpatient	3□ DOA Othe	er: 4 Nursing H	lome 5 ☐ Resid	ence 6 🗆	Other (Specif	<b>5</b> /)
Ē	10 Tel	<u></u>	27. Manner of Death 1	28a. Date of Inj (Month, Da	ury 28 ay Year)	Bb. Time of Injury	28c. Injury Work	rat c?	28d. Describe h	ow injury oc	curred	
Sic	tend seath tor: / the f	cat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	he -				Yes 2 No				
Division of Vital	el or A s after il Direct	Certification:	4 Homicide determine	d 289. Place of It	itc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (Si City or Town		imber or Rura	al Route Number,
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edicai (	29a. Certifier  (Check only one)	Physician: To the best aminer: On the basis of and manner s	of examination	edge, death n and/or invi	occurred at the timestigation, in my or	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and ate and plac	manner as s	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and marrier s	tateu.		29c. License	number		9d. Date sic	gned (Month,	Day, Year)
	⊢s⊢ŏ						DO	2323			4106	
		Ī	30. Name and address of person wh		death (Item 21	3a) (Tvna 🗜	Print)	5257		/	1000	
54	1-10+1		Do Wasio	112	( U	Pal	Court	1+	o MI	217	40	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signaturi	9		1.37		<u></u>	, -	
	Registr	ar	OCT 05	2006	wa li	4. Sp.	and					

			1 - For State Registrar	State of M	laryland / De <i>C</i> e	partment of ertificate of	Health : Death	and Mer	ntal Hy	giene	000	5	32879
	Physici	<b></b>	1. Decedent's Name (First, Middle, Las					2.	Date of De Month	ath Day	Y.	ear	3. Time of Death
	/Medic		Helen MacFarland						ep.	23,	200	6	9:40 a M
	Examir	er	4a. Facility Name (If not institution, given FutureCare Chesa		)	4b. City, Town,	or Location	of Death			County of I		lo1
	Funeral	-	5. Social Security Number 6. S		ge (In yrs. last birthda	v) If Under 1 Yea.	r If Under		Date of Birt	th		Birthpla	ice (State or Foreign
	Director		185–20–6863	□M 2 <b>⊠</b> F	77 Yrs.	Months Days	Hours		Month, Da			Count	PA
-	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10	d. Inside City Limits
	Maryla fed al	tor	DE New Cas	tle	1	lmington						10	1 ☐ Yes 2 No
	n the	Irec	10e. Street and Number			10f. Zip Code				10g. Citiz	zen of Wha	t Count	ry?
	ath wit	ralD	112 Lynthwaite Fa	rm Lane			19803				USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 ehow appringury or other traumatic event, I'm Medical Exert and unal be invilled at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 M If Yes, Give Year or Dates:	?	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 250 No	ban, Mexicai	n, Puerto Rica	Yes or No an, etc.)	i	14. Race - Black, \ Specify:	White, e	tc.
5-0	"natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>	(Gi	edent's Usual Occu ve kind of work done	e during mos	st of working		16b. Kir	nd of Busin	ess/Indi	ustry
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life	. DO NOT use retir <b>Homen</b>					Hor	me	
	Hygi Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Moth	er's Name <i>(Fi</i>	irst, Middle,	Maiden	Sumame)		
/lan	Mental Mental arked	To B	Robert MacFarla	nd			Mi	riam E	nck				
, Maryland	ind 2 sho alth and I 27 is ma		19a. Informant's Name/Relationship ( Jennifer Haught			iling Address (Stree Boone Tr						te, Zip ( 146	Code)
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			position (Name of ematory or other pla Cremator		Sep. 200	26,		cation - City		
Balti	permit. Departn Imports any inju		21. Sign ure of F neral Service Licen	holon	1)	22. Name and Addi Barranco 495 Gov.	& Son: Ritch	s, P.A	. Seve	erna erna	Park Park	Fun MD	eral Home 21146
			20a. Party Enter the disease, or con- shock, or heart failure. List only	olications that cause one cause on each I	d the death. Do not e	nter the mode of dy	ing, such as	cardiac or re	spiratory ar	rest,			Approximate nterval Between
1	Physician		Immediate Cause (Final disease or condition	Pan	ncest		an					-	Onset and Death  7 Months
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
		ē	Secrentially list conditions,	b. Due to (or as	a consequence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ó	icate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):								
8760,	ate be hysici the bu	dical		d								-	
Φ	ertification by the second sec	Med	IF FEMALE:	00-14	2.0200								
P.O. Box	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	Ectopic pregnand	су			2	3d. Date of Month		/ Day Year
o.	at the d by the tached	hysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
	es the	ρ	Part II. Other significant conditions o	ontributing to death t	out not resulting in the	underlying cause g	iven in Part I	l-	23e. Did to				cause of death?
COL	w requir s been si should	lete							24a. Was	an /	24b. Wer	e autop:	sy findings available
Division of Vital Records,	iician: The lav certificate has rector, page 2	Completed	_12						autop	rmed? 20 <b>X</b> No	prior	to com	pletion of cause of
5	ysician: is certific director,	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	05550		4.5	e of Death (Cl					
o	문 판 B	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpati	ury 28b. Time	of 28c. Inju	ary at	ursing Home 28d.	5 🔲 Resid			Specify)	
0	nding I ath. r: After e funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	<i>ry Year)</i> Injury		ork? ]Yes 2. ☐	No					
Divis	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm, stc. (Specify)	street, factory, office			Location (S City or Tow			r Rural	Route Number,
	To the Hospital or Attenwithin 24 hours after deatle to the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, de of examination and/or lated.	ath occurred at the t investigation, in my	ime, date an opinion, dea	nd place, and ath occurred a	due to the out the time, o	cause(s) a	and manne place, and	r as sta due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		_		se number			29d. Date	signed (M	lonth, D	ay, Year)
}			Manho	M.	D	D	3950	5	5	epte	mbl	22	15, 2006
			30. Name and address of person who	completed cause of	death (Item 23a) (Typ	Print)	ribal	×	Mal	en	Bus		21061
4	Sta	te	31. Date filed (Month_Day, Year)	32 Regist	rar's Signature	books 5						V D	21001
	Registr	-	2 3 6 C	UND I	W 10 19	100							

		- State Amend #1, 10- Registrar 1. Decedent's Name (First, Middle, Last)	Joseph	ine M	lalamph	v Bia	nco	2. Date of Dea			3. Time of Death
Physicia /Medic		<del>J</del> e	sephine Mal	amphy	- -	y Dia	neo	Septem			9:25 P M
Examin		4a. Facility Name ( <i>If not institution, giv</i> e s Gilchrist Hospice	treet and number)		4b. City, Tow	own, or Locat SON	ion of Death			unty of Death altimo:	ce
Funeral Director		210 24 0393	7. Age (In 7. 75	yrs. last birtho Yrs	Months	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day Jan 1,	v. Year)		place (State or Foreign http) /land
M H	-	Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town o	or Location					· ·	10d. Inside City Limits
, and Mental Hygiene. Is marked other than "netural", or itema 23a or 28a-f ehow reumatic event, the Medical Examiner must be notified at	ţo	MD Howard	E	Elkridq	re						1 ☐ Yes 2 XNo
or 28	Funeral Director	10e. Street and Number			10f. Zip (					of What Cou	•
na 23a	erai	6155 Shadywood Roa	d Unit 303	in II S	1	075	Origin? (Spe	acify Yes or No.		ed Stat	
or items		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 XNo	0.0.	13. Was Decede			Rican, etc.)	i	Black, White,	
LEXE	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes 2		спу: 			ecify: Wh:	
"netur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(0	ecedent's Usual Give kind of work fe. DO NOT use	done during	most of worki	ing	16b. Kind	of Business/In	dustry
other than vent, the Ms	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Co	mptro11	er			Seli	E Emplo	oyed
d other	Be	17. Father's Name (First, Middle, Last)						(First, Middle,		mame)	
7 is marked of treumatic ev	၉	Salvatore Esposito  19a. Informant's Name/Relationship (Type	ne Printl	19h M	failing Address (			Barchi		um State Zie	Code
2 2		Dr. Emidio A. Bian			5 Shady						7 (2004)
fitem 27 ir other tre		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re		Db. Place of D	isposition (Name crematory or oth	e of er place)	-	Date	20c. Locati	ion - City or To	own, State
tant: if jury or		4 ☐ Donation 5 ☐ Other (Specify)	G	Carriso	n Fores		1	-2006		ys Mill	
Department of Important: if eny injury or once.	1	21. Signature of Funeral Service Livy e	is with	1044							lly FH Inc. MD 21043
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the ce cause on each line.	death. Do not	enter the mode	of dying, sucl	h as cardiac d	or respiratory ar	rrest,		Approximate Interval Between
ysician		Immediate Cause (Final disease or condition resulting in death)	6astric	- Ca-	icer						Onset and Death
Medical aminer			Due to (or as a cor	nsequence of)	:						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	section of							
-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	secures of							
	dical E		Due to (of as a cor	isaquarica or)	•						
as the	fedic										
for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐	Fetal death	3 ⊟Ectopic pre				23d	Date of delive	ery Day Year
	ysici	1 Yes 2 No 9 Unknown	4☐Pregnant at time 9☐ Unknown	of death	5 ☐ Other (spe	cify)					July 100
ned by e detac	by Physi	Part II. Other significant conditions con	tributing to death but not	t resulting in th	ne underlying ca	use given in P	art I.	23e. Did to	obacco use	contribute to t	he cause of death?
								101	∕es 2 🖎	rố 3∏Prot	oably 4 DUnknown
has be e 2 sh	ompieted							24a. Was autor	an 2	4b. Were auto	opsy findings available impletion of cause of
certificate ha	O.	25. Was case referred to medical						1 ☐ Yes	2No	1 ☐ Yes	2 No
is certi	To Be	examiner?	ospital:	2 ☐ ER/Outpa	atient 3□ DOA	104		n <i>Check</i> only o		Other (Specia	w/tospice
들 ~		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Tim	ne of 28	c. Injury at Work?		28d. Describe h			
death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a Place of Injury	At home form	M .	1 Tes		28f Location (6	Stroot and M	umbor or Rus	al Route Number,
Director: d in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	pecify)	i, sireet, lactory,	OIIICO		City or Tov		umber of Aut	ar noute reuniber,
<b>ĕ</b> ■	edical C	29a. Certifier (Check only one)  (Check only one)	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, omination and/o	death occurred a or investigation, i	t the time, dat n my opinion,	e and place, death occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as s ice, and due to	stated. the cause(s)
To the Funeral completely filled	Med	29b. Signature and title of certifier	and maning stated.		29c.	License numl	ber		29d. Date si	gned (Month,	Day, Year)
4		Horan Blue	Sino		D	006119	79		Oct.	1,20	06
		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Ty					) 0		
-		Jason Black, 65	65 NORTH 1	$\wedge$ $\sim$	(	7 11 -	C 1 -	. //	_ A O	/ 7 ~ # -	

State of Maryland / Department of Health and Mental Hygien 32881 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Fannie N. Beachy 4:50 October 6, 2006 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 96 206-40-7783 Director 13, 1910 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow T is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Marilial Exp. ultier : sust be notified at 1 Tyes 2 X No Funeral Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 758 Springs Rd. 21536 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fit timent of Health and Mental H tant: if Item 27 is marked oth jury or other traumatic even Noah Hershberger Savilla Yoder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Simon Beachy/Son 11536 National Pike, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or ance. Oct. 9, 2006 Salisbury, PA 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. 21. Signature of Fune La Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. eumal P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGESTIVE **Physician** /Medical Examiner MEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ROMBOEMBOLIC or Attending Physician: The law requires that the death certificate be executed burial-transit ettending physicien and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2) No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 22000 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25e Cartifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58655 auras talsa hat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRANTSVILLMB 21536 SABAHAT NAWAR 32 Corporate 31. Date filed (Month, Day, Year) 82. Registrar's Signature State OCT 10

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiens Z 0 0 6 For State Registra 32882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 8:30 Eugene Dale Beachy October 8, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3425 Chestnut Ridge Rd. Grantsville Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sept. 9, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F 215-34-4959 71 1935 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Garrett Grantsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3425 Chestnut Ridge Rd. 21536 USA itama 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or itama 23 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernon Beachy Gertrude Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhua Jean Beachy/Wife 3425 Chestnut Ridge Rd., Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ö 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Country Side Crematory Oct. 11,2006 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service uman P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Esophagoa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home Sesidence 6 Other (Specify) 3 DOA Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C ritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H26154 Wolf Acres Danse Her 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 32883 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kenneth P. Crawford **Physician** Sept 26,2006 11:26am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb 28, 1920 Suburban Hospital Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**□M 2□F Yrs. Cornelia, GA Director 329-24-8896 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel", or Iteme 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at YYes 2 □ No MD Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 Thornapple St. Funeral 20815 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 To No If Yes, Give Year or Dates: 53-62 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes ♣☐ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Language Analyst Fed Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wyly Crawford Lassie Penland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila O. Asher Crawford/Wife of Health Item 27 4100 Thornapple St., Chevy Chase, MD 20815 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o National Crematory 4 □ Donation 5 □ Other (Specify) 10-9-2006 Falls Church, Va 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC 100 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUCCARDIAL Physician IMFARUTION MINVES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Antisto scuttone GARDIO VALLIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine this certificate has been signed by the attending physicien end ral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): 68760, Physician/Medical P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ∑ No 24a. Was an oerform 1 Tes 2 No Vital filled in by the funeral director 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ★ R/Outpatient 3 DOA 1 🗌 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Al within 24 hours efter or To the Funeral Direct completely filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31027 26-2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1

Registrar

State

O'BRIEN

31. Date filed (Month,

m

0 3 2006

1 Jac Am

9

0

1

ڡ

50

SLOD OLD GETTGETOWN RD

32. pegistrar's Signature

BOTHESDA

State of Maryland / Department of Health and Mental Hygien 2 0 0 5 32884 For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year **Physician** 7, 2006 3:40 P M October 0 Robert Anderson Carr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland **Allegany** Memorial Hospital 8. Date of Birth (Month, Day, Year) Nov. 28,1968 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 1∭ M 2□ F Months Days 37 Director Cumberland, MD 213-02-2696 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Allegany Rawlings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21309 Burke Hill Road, S.W. 21557 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Folces: 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Unknown 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber Plumbing and Heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Thomas Carr Barbara Ann Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Paul T. Carr/Parents 21214 Burke Hill Road, S.W. Rawlings, MD 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Oct. 11 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waxler Cemetery 2006 Rawlings, MD 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 anon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Aspiration Pneumonia 1 week /Medical Due to (or as a consequence of) Examiner Dehydration day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Ileus 1 week that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Anoxic Encephalopathy l year IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed Anemia, Urinary Tract Infection 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificete has 1 Yes 2X No To the Hospital or Attending Physician: : After this certifical funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 21 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) heil 940 October 8, 2006 D58655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S Nawab, PO Box 265, Grantsville, MD 21536 31. Date filed (Month, Day, Year) OCT 1 7 2006 2. Registrar's Signature State Registrar

			State of Maryland / Dep		lental Hygier	2006	32886
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. I	40.C 0 0 0	3. Time of Death
	Physici		Louise L. Cherrix			Day Year	17:16 PM
	/Medio Examir		4a/Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	01	4c. County of Death	11.16
			Peninsula Regional Medical Center	Salisbury		Wicom.	ico
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birthr	
	Director		Usuel Residence of Decedent		12-22-19	124 V	A
	yland		10a. State 10b. County 10c. City, Town or L	ocation		1	10d. Inside City Limits
	9 Mar	ctor	VA Accomack China	oteague			1) Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Oode	10g. (	Citizen of What Cour	ntry?
	e 23e	rai	4184 Cherrix Lane	IN Design of the control of the cont		U.S.H.	
	fter d	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 127No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
8	rai', o	þ	3 ☐ Widowed 4 National If Yes, Give Year or Dates:	1 ☐ Yes 2 StNo Specify:		Specify: W	hite
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "netural", or iteme 23s or 28s-f show other treumatic event, the Medical Exeminer must be notified at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki	ng 16b.	Kind of Business/In	dustry
121	within ane. then	dm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		CIE	
о 2	Hygie Hygie other		17. Father's Name (First, Middle, Last)	Homema Ker  18. Mother's Name	(First, Middle, Maid	len Sumame)	
an	Mental Mental Ked c	To Be	Melson Leuris	Hottic	Thorn	ton	
ary	and N		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura		1	Code)
	D = V =		Jean Pruitt Daughter P.O	Box 116 Green			33356
Baltimore,	Pages 1 nent of H int: If ite iry or ott		1 Experial 2 Cremation 3 Hernoval from State	ematory or other place)	_	Location · City or To	
<u>=</u>	it. Pa intmen intant: njury			Caylor (cmerry 10)	3/0L h	emperan	conlegin
Ba	permit. Pages 1 and Department of Healimportant: if Item 2 eny injury or other once.		Amanda e Polt	2. Address of Facility	e Inc. 63		UA a3336
	•		23a. Part1. Enter the disease, or complications that caused the death. Do not en	eter the mode of dying, such as cardiac of		127 Church	Approximate
,	Physician	8 1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	cardiovarcular d	crease		Interval Between Onset and Death
ŕ	/Medical		resulting in death)  a. Due to (or as a consequence of):	CDO ST. CONT. OFFICE	( •		- March
	Examiner		Sequentially list conditions, b.				
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
<u>,</u>	execu n end ial-tra	Ехаг	that initiated events c. Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed sie has been signed by the ettending physician end page 2 should be detached for use as the burial-transit	dical	d				
9	artifica ing ph e as th	Med	IF FEMALE:				
Rox	eath certific ettending p I for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delive Month	ery Day Year
	at the de by the e	Completed by Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)			
2	res that tigned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to the	ne cause of death?
<u>ras</u>	w requires been sign should be	q pa	clostridia difficile colitis		1 🗆 Yes	2.2No 3☐ Prob	ably 4 Unknown
<b>Records</b> ,	law re as bee 2 sho	plet	Diabetes mellitus		24a. Was an	24b. Were auto	psy findings available impletion of cause of
ř		Com	dementia		autopsy performed?	?death?	
Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
	Physic this cral dir	. To	1 ☐ Yes 2 ☐ No Hospital: ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence	6 Other (Specify	y)
Division of	ding P th. : After I	Certification;	→ Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No	.ou. Describe riow in	lary occarred	
N S	Attendi	Iffica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		and Number or Rura	I Route Number,
בֿ	Itel or rs afte el Dir led in	Cert	building, etc. (Specify)		City or Town, Sta	110)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	cal	29a. Certifier (Check only Quantum Check only (Check only Quantum Check only Quantum Check only Quantum Check only Quantum Check only Quantum Check Only Quantum Chec	th occurred at the time, date and place, a typestigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as stand place, and due to	tated. o the cause(s)
	thin 2 the on the	Medical	one) and nanner stated.  29b. Signature and title of-pertifier	29c. License number		Date signed (Month,	
)	F 3 F 8		· Wille	030853	10	12/06	
	Alk,		30. Name and address of person who completed cause of death (Item 23a) (Type			1700	1
	1		charles B. Silvia, Tr mo Per		ledical Ger	nter Salis	buy mus
de	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
	Registr 	ar	OCT 0 3 2006	Carlo I			

LAN

State Registrar 31. Date filed (Month, Day, Year) 2006

29b. Signature and title of certifier

30. Name and address of person

WASHINGTON HOTS. WESTMINSTER, M& 21157 217 S. KALARIA 32 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

and manner stated

D 23015

29d. Date signed (Month, Day, Year)

9/26/06

			State of Maryland / Depart	ment of Health and Me		2006	32888
			Registrer  1. Decedent's Name (First, Middle, Last)		Reg. No.	2000	3. Time of Death
ı	Physici		FANNIE MIRIAM CALIMESE			ay Year	5:00AM M
	/Medic Examin			b. City, Town, or Location of Death		c. County of Death	
	LXamii		FUTURECARE PINEVIEW NURSING & REHAB	CLINTON		PRINCE	GEORGES
	Funeral		N N	f Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year	r) Cou	
	Director		134 22 8165 Superior State Sta		APR. 29, 1	.925 SOUT	H CAROLINA
	land ow		10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits
	Many First	to	MD PRINCE GEORGES TEMPLE HI	LLS			XXYes 2□No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	ntry?
	ath wi		2503 GAITHER STREET	20748		NITED STA	
	ltems	Funeral		s Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
36	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow te Masical Examirer masi be ridilised at	P P	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ACTNO If Yes, Give 1 ☐ 1 ☐ Yes Or Dates:	Yes XXNo Specify:		Specify: BLA	CK
Ö	72 hou	Completed		it's Usual Occupation of of work done during most of working	16b. I	Kind of Business/Ir	ndustry
7	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	9		
7	filed w Hygier other th		12TH INVENTO	ORY MANAGEMENT SPI	ECIALI\$T (First, Middle, Maide		GOVERNMENT
auc	D E D S	) Be		CARRIE		n damame)	
Maryland 21215-0036	s 1 and 2 should f Health and Men Item 27 is marke other treumetic	J.	WALTER ROBERSON  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing A	Address (Street and Number or Rural		or Town, State, Zij	o Code)
	27 Ith		BARBERA J. PRINGLE BROOKS / POA 2510 G	GAITHER STREET TI	EMPLE HILI	LS, MD 20	748
ore,	es 1 au of Hea f Item r othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Removal from State	on (Name of Da ory or other place)	ate 20c. L	Location - City or To	own, State
altimore,	Pages ment of I ent: If Its ury or o		*4 □Donation 5 □Other (Specify) LINCOLN ME	EMORIAL CEM. 10/0	7/2006	SUITLAND,	MD
Balt	permit. Pages Department of Importent: If I any injury or one			ARSHALL'S FUNERAI 308 SUITLAND ROAI	L HOME OF	MARYLAND AND, MD 2	, INC.
			23a. Part1. Ener the disease, or complications that caused the death. Do not enter t shock, of heart failure. List only one cause on each line.				Approximate Interval Between
U,	Enysician		Immediate Cause (Final disease or condition ADVANCED CARDIOMYOF	PATHY			Onset and Death  1 YEAR
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	Lxammer	Jan 1	b. CONGESTIVE HEART FA	AILURE			I WOALL
	ted	nine	cause. Enter Underlying Cause (Disease or injury CLIDONIC LIMC DICEASE	· c			1 YEAR
<b>_</b> ,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last c. CIRCUNIC LUNG DISEAS  Due to (or as a consequence of):	) L'a			I ILAK
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d. DEMENTIA				1 YEAR
9	rtifica ng ph as th	Medi	IF FEMALE:		1		
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ec	ctopic pregnancy		23d. Date of deliv Month	ery Day Year
o.	the a	ysic	1 ☐ Yes XX No 9 ☐ Unknown 9 ☐ Unknown	ther (specify)			
<u>α</u>	that the de led by the detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the unde	orlying cause given in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ds	puires n signe	d by			XX Yes 2	2 □ No 3 □ Prof	bably 4 Unknown
00	s been si s been si s should I	Completed			24a. Was an	24b. Were auto	opsy findings available
æ	The law ate has page 2 s	mo			autopsy performed? 1 ☐ Yes ※XXN	death?	mpletion of cause of 2 No
İta		Be C	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
<u>خ</u>	S S	은	1 ☐ Yes XX No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: XXX Nursing Hom			(y)
n C	ding Ph h. After thi funeral	lon:	27. Manner of Death  XXNatural 5 ☐ Pending (Month, Day Year)  28b. Time of Injury	28c, Injury at Work?  M 1 Yes 2 No	Bd. Describe how inju	iry occurred	
Division of Vital Records,	l or Attending after death. Director: After I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street		8f. Location (Street a	and Number or Rur	al Route Number,
<u>&gt;</u>	afte Dir	Certification:	4  Homicide determined building, etc. (Specify)	,,	City or Town, Star	(e)	
	To the Hospitel or Attent within 24 hours after death to the Funerel Director; completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or control on the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause(s d at the time, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
	Fo the vithin Fo the complex	Me	29b. Signature and title of centifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
	2		1/20ml	D24535	OCI	TOBER 03,	2006
	BI		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin		FMT 0 101	OT TARROW	MD 20725
	7	to		LD BRANCH AVE. SU	LTE C-101	CLINTON,	MD 20/35
	Sta Registi		30 Tilly (Mani 2006) Albert 32. Resistrar's Sporter				

DHMH 17 Rev 1/2001

Registrar

		•	1 - For State Registrar	State of M	larylan		artment of H <i>tificate of L</i>		nd Mental Hy	giene Reg. No.	006	32890
	Physici /Medio		1. Decedent's Name (First, Middle, L Marian Delaney	ast)					2. Date of Do Month Septen	nzie 29	Year Jouf	3. Time of Death
يالمي	Examir	er	4a. Facility Name (If not institution, gashady Grove Adve	ntist			4b. City, Town, or Rockvil	le		Mon	unty of Death	У
	Funeral Director		5. Social Security Number 6. 579-74-4152  Usual Residence of Decedent	Sex 7. A 1 □ M 2 1 F	47	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bi (Month, D	0, 195	9. Birth Cou Wash	place (State or Foreign intry) nington, DC
	Maryland I-f show	tor	10a. State 10b. County  DC			y, Town or Lo						10d. Inside City Limits 1   Yes 2 □ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 1318 Kenyon Stre	et NW			10f. Zip Code 20010			10g. Citizen	of What Cou	intry?
036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	b	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? <b>X</b> No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 201 No	spanic Orig n, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Race - Amer Black, White ecify: <b>B1</b>	, etc.
21215-0036	within 72 horens. ene. then "natura he Medical B	Completed	15. Decedent's (Specify only highest g	Education rade completed)  College (1-4or	5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most )	, and the second		of Business/li	ndustry
land 2	ld be filed ental Hygi ked other Ic event,	To Be Co	17. Father's Name (First, Middle, Las Arthur Whittaker	st)		1Kimili	Beracive	18. Mother	's Name (First, Middle Culberts	, Maiden Sur		
Maryland	nd 2 shou aith and M 27 is mar ir traumat		19a. Informant's Name/Relationship Darrell Delaney	· • ·		1	-		or Rural Route Numb	-		
Baltimore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec		B C	emetery, crer	sition (Name of natory or other plac <b>femorial</b>	· 1	Date 0/5/2006	20c. Locati	on-City or T	
Balt	permit. Departr imports any inja		21. Signature of Follows Service Lie	eqsee					Johnson and reet NW Wa			neral Home 20011
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List onlimediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or a	line. PAST s a consequ	uence of):	er the mode of dying	g, such as c	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death Chronic
κ 68760,	ertificate be executed ing physicien and e as the burial-transit	dicai	that initiated events resulting in death) Last	Due to (or a								
P.O. Box	requires that the death certific neen signed by the ettending p hould be detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ②Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	Ideath 3	Ectopic pregnancy Other (specify)			23d.	Date of deligion. Date	very Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.		tobacco use o	contribute to	the cause of death?
II Reco		Completed							24a. Was auto perf 1 🗆 Yes		prior to o	opsy findings available ompletion of cause of
Division of Vital Records,	Attending Physician: The law ir death. ector: After this certilicate has t by the funeral director, pege 2 s	ation; To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manper of Death   Natural  5 Pending   1 Accident investigati	Hospital: Inpat 28 Date of In (Month, D	iury	ER/Outpatien 28b. Time of Injury	28c. Injury Work	en: 4 □ Nur ⁄at	of Death (Check only sing Home 5 Res 28d. Describe	idence 6 🗆		ify)
Divis	al or Atten s after deal al Director: ed in by the	Certification;	3 Suicide 6 Could not determine	A 286. Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office			(Street and Ni wn, State)	umber or Rui	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex-	Physician: To the bes aminer: On the basis and manners	of examina	wledge, death tion and/or in	vestigation, in my or	oinion, death	place, and due to the n occurred at the time	, date and pla	ce, and due	to the cause(s)
	To To com	X	29b. Signature and title of certifier	ul	death (tree	220\ /T	29c. License	173	_	Sople	gned (Month	29, Year) 29, 2006
	Sta	te	31. Date filed (Month, Day, Year)	o completed cause of	770	7 M.	oclical	Con	TER DI	1. 1	MIC	1.20878
	Regist		OCT 0 4 2006	Micus 1	K 14	porte						

31. Date filed (Month

**Funeral** 

Director

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No.2 U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 10TH, Year 2006 **Physician** Dicken 20:24 Werner Frank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☑ M 2 □ F Mar 22 213-24-5608 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Cumberland MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 205 Baltimore Avenue, Apt. 310 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Dates: Korea 1 Yes 2 No Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Housekeeping Dept. Miner's Hospital 18. Mother's Name (First, Middle, Maiden Sumame) Viola B. DeLuca Dicken 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
405.44 Ellorolia Road Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10/13/2006 Flintstone Rocky Gap Veterans Cemetery MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASPLICATION NEUMDNIA wee Due to (or as a consequence of): EMORRHAG! Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 X Unknown ATRIAL FIRRILL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? PANCREATITIS 2□ No 1 Yes No No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 TYes 2 TNo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 10-11-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD 21502 HASNAN Seton Drine WIRASA 900

State Registrar 32. Aegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene, For State Registra 32892 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Ryan Devereux, III September 30, 2006 5:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing Home Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year | 11/21/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1X M 2 ☐ F 579 07 8510 83 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ➡ No Director MD Columbia Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6334 Cedar Lane 21044 USA Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 No WWII 11. Marital Status hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2X No Specify: Specify: White 3X Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Custom Home Builder Construction is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be 1 nent of Heeith and Mental I int: If item 27 is marked of Joseph F. Devereux Helen Kemp ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Shriver Devereux/Son 1850 Florence Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any injury or St. Louis Church Cem. 10/5/2006 Clarksville, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01442Murica .. Kadas 4112 Old Columbia Pk. Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Broncho Pneumonia Five Days /Medical resulting in death) Due to (or as a consequence of): Examiner Cerebro-Vascular Accident Months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Hypertension Years and Due to (or as a consequence of) Box 68760. the attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 1 Yes 2X No 1 Tyes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2XXVo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М after death 2 Accident in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a completely filled 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. alles N.B. D30469 10/2/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. Vellanki 8850 Columbia 100 Parkway #308 Columbia, MD 21045 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State OCT 0 3 2006 Registrar

**ORIGINAL** 

				partment of Health and Mertificate of Death	lental Hygier	Z 11 11 15 15 15 15 15 15 15 15 15 15 15
*	Physici		1. Decedent's Name (First, Middle, Last)  Faith Jean Dorsey		2. Date of Death Month Sentember	Day Year 12:00 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
\$ 30 April		36 SE	Anne Arundel Medical Center	Annapolis		Anne Arundel
Va	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda Yrs.	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 6-16-19 <sup>t</sup>	ar) 9. Birthplace (State or Foreign Country) 111inois
	P .		Usual Residence of Decedent			10d. Inside City Limits
	Aaryla f ehov	ō	10a. State 10b. County 10c. City, Town or			1 ☐ Yes 2 🛣 No
	28a-	Director	Maryland   Anne Arundel   I	dgewater 10f. Zip Code	10g.	Citizen of What Country?
	23a o	al D	1311 Sundee Drive	21037		USA
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if item 27 ie marked other then "natural", or iteme 23a or 28a-fehow empt figury or other traumatic event, it a Madical Examination and page.	by Funeral	1 □ Never Married 2 ሺ Married 1 □ Yes 2 ሺ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
9	72 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	16b	. Kind of Business/Industry
2	hen .	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9	D 11: 1:
22	Hygier ther th	CO	12th 17. Father's Name (First, Middle, Last)	ompositor	a (First, Middle, Maid	Publishing
Baltimore, Maryland 21215-0036	lid be fental rked o	To Be	Philip Ellington		h Cox	
Mary	2 short			ling Address (Street and Number or Rura		
e,	1 and Health em 27		Edward E. Dorsey, Jr./ Husband 1311			Location - City or Town, State
JOE	Pages nent of innt: If its int: If its		1 ☐ Burial 2 [X]Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Cr			igewater, MD
a E	permit. F Departm Importar eny Injui			22. Name and Address of Facility Ge		
<u> </u>	82E\$8		10 Value	2973 Solomons Isla		
Ŧ			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	y factine		
	Examiner		Sequentially list conditions b. Lung (	y Facture Career with r	negasta	sis
	gi ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	xecute and al-tran	Examiner	resulting in death) Last  C. Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	calE	d			
89	ing phy a as th		IF FEMALE:			
P.O. Box 6	attend for use	lan/	23b. Was decedent pregnant in the past 12 mgnths?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	t the di by the ached	hyslo	1 ☐ Yes 2 A o 9 ☐ Unknown	- Cirio (specify)		
_	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the			co use contribute to the cause of death?
oro	requir	eted	Lest Contro vascular 1	1	1	2 No 3 Probably 4 Maknown
Records,	a 3.0	Completed	- NJA Coura Vascular F	recident	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ita	rtificat	Be C	25. Was case referred to medical	26. Place of Deatl	1 ☐ Yes 252 1 (Check only one)	No 1 ☐ Yes 2 ☐ No
× ×	hysic his ce il direc	ToE	examiner?  1 Yes No Hospital: Inpatient 2 ER/Outpati		me 5 Residence	6 □Other (Specify)
Division of Vital	ding P. After t	lon:	27. Manner of Death  10 Natural 5 Pending (Month, Day Year)  2 Nacrident investigation 2		28d. Describe how in	njury occurred
<u>N</u>	Atten r deat ector: by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of tnjury - At home, farm,			and Number or Rural Route Number,
ā	ital or rs afte rat Dir led in	Cert	3, 3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,		City or Town, St	·
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within Fo the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)			India Asso Hers atta	Doc13371	4	9/25/06.
	10		30. Name and address of pelson who completed cause of daith (Item 23a) (Type AMC 2001 Modical F	Print) way, Annap	Dis , ma	21401
	Sta			<b>1</b> 993		
1	Registr	ar	SEP 2 7 2006	back		

			For State Registrar	State of	Marylan	•	artmen tificate						2006	328	94
	Physici	an	Decedent's Name (First, Middle, La FLORA CAROLY		BERG				_		2. Date of Dea Month OCTOBER	Day	Year 06	3. Time of 3:55A	Death M
	/Medic Examin		4a. Facility Name (If not institution, given 3122 GRACEFIELD RO		ber)			Town, or /ER SI	Location o			4c. (	County of Dea		
	Funeral Director		5. Social Security Number 6.5		. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. 8 Min.	8. Date of Birt (Month, Day JAN . 9,	v, Year)	Co	hplace (State or ountry) MANY	Foreign
	D		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				JAN. 7,	1,2,		10d. Inside Cit	y Limits
	e Maryl Ba-f eho	Director	MARYLAND MONT	GOMERY		SILVER								1X∑ Yes	2 🗆 No
	h with the 23s or 2	al Dire	10e. Street and Number 3122 GRACEFIELD ROA	D #413			10f. Zip	2090	4		U	10g. Citiz INITED	en of What Co STATES	OF AMERIC	SA .
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. do ther then "natural", or iteme 23s or 28s-f ehow event, the Madral Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Dat	es? PNo		Was Deced f Yes, spec i ☐ Yes				ify Yes or No- lican, etc.)		4. Race - Ame Black, Whit Specify: V		
Maryland 21215-0036	within 72 ho lene. then "natur Ine Wedical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12) 12	ducation ade completed) College (1-	4or 5+)	lite.	dent's Usua kind of wor DO NOT us OMEMAK	rk done d se retired,	lurina mos	t of working	g	16b. Kir	od of Business	·	
yland 2	d be ental	To Be C	17. Father's Name (First, Middle, Las JOSEPH WEISSMAN	")						er's Name LORA	(First, Middle, "UNKNOW!		Surname)		
	id 2 sh lth and 27 ie m traum	. U	19a. Informant's Name/Relationship WERNER D. FRIDBERG	-			ng Address GRACEF			er or Rural #413,	Route Number	SPRI	Town, State, . NG, MD 20	Zip Code) )904	
Baltimore,	Pages 1 an nent of Heal int: if item 2 ury or other		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control			Place of Disponentery, creation MEM	natory`or o IORIAL	ther place GARDE	NS 1	LO/03/		OLNI	cation - City or EY, MARYI	AND	
Balti	permit. Pag Department Important: it eny injury o		21. Signature of Funeral Service Lice	nsee									FUNERAL I	HOME, INC	
	Physician		23a. Part1. Enter the disease, or con shock heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	ch line.	th. Do not ent		e of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bety Onset and E YEARS	veen
	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):									
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consec										
8760,	icate be executed physician and s the burial-transit	cal		_ d	w as a consec	querios ory.									
P.O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2∐Feta .ntattime.ofo	al death 3	⊒Ectopic pr ∃ Other <i>(sp</i>				and and and	2	3d. Date of de Month	•	'ear
	The law requires that the ste has been signed by the sage 2 should be detache	ě	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the u	nderlying o	ause give	en in Part I	l.		obacco u /es 2	57	o the cause of d robably 4 □t	
Records,		Completed			-				-	-	24a. Was autor perfo 1 Yes		24b. Were a prior to death?	utopsy findings a completion of ca 2 No	available ause of
Vita	Physician: The k rthis certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		150/Out-#-		Othe			(Check only one 5 And Residue)			4.1	
Division of Vital	ling P	atlon: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date or (Month		28b. Time o Injury		8c. Injun Work		2	8d. Describe I		S □Other (Spe y occurred	эсігу)	
Divis	i di di	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 289. Place	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office		2	8f. Location (: City or To			ural Route Num	ber,
	To the Hospitei within 24 hours a To the Funeral i completely filled	edical		hysician: To the miner: On the ba	sis of examina										)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	12/1.			290		number				e signed (Mon		
)			•	completed	A aldert (II	m 22c) /T	Priet'	D24	035				ctober	2, 200	D
	5		30. Name and address of person who Eugenio S. Macha	do, MD		3110 G	racef		Road	l, Si	lver Sp	ring	g, MD 2	0904	
	Sta Regist		31. Date filed (Month, Day, Year)	2006 32.	gistrar's Sign	ature	me	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

		_	For State Registrar	State of Marylan	•	artment o		nd Me		iene2 () ()	6	328	95
			Decedent's Name (First, Middle, Last)						2. Date of Deat Month		ear 3.	Time of De	eath
	Physicia /Medic		Anna Laura Frere					**	Septemb	er 26, 2	006	6:36	a <sup>M</sup>
1	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Tow	n, or Location of	Death		4c. County of	Death		
			Washington Adventi				ma Park			Montg			
	Funeral		5. Social Security Number 6. Sex 1 □ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age ( <i>In yr</i> s. <i>I</i> 4. 2⊠ F	ast birthday) 54 Yrs.	Il Under 1 Ye Months Da		Min.	8. Date of Birth (Month, Day, Oct. 12	, 1951	Country)		Foreign
Ų.	Director		Usual Residence of Decedent		J4 ···				001. 12	, 1901	Virg	шта	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. l	nside City	Limits
	a-f st	ctor	Virginia Alexandri	a City A	lexand	ria					1	Yes 2	□No
	or 28	Directo	10e. Street and Number			10f. Zip Cod	ie		1	0g. Citizen of Wha	at Country?		
	eth w	rall	231 East Taylor Ru			2231				United			
	item item	Funeral		<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 XNo</li> </ol>	S. 13.	Was Decedent If Yes, specify (	of Hispanic Orig Cuban, Mexican,	in? (Spec , Puerto F	city Yes or No- lican, etc.)		American Ir White, etc.	ndian,	
5	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Il Yes, Give Year or Dates:		1 □ Yes 2 🗖	No Specify:			Specify:	aucas	ian	
9500-61212	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show shift the Modical Examinar must be notified at		15. Decedent's Educa		16a. Dece	dent's Usual Oc	cupation	of workin	<i>a</i>	16b. Kind of Busin			
Š	thin 7	Completed	(Specify only highest grade and Elementary/Secondary (0-12)	College (1-4or 5+)			one during most tired)	Of WORKIN	9				
7	ygien ygien yer th	Con	12		Но	memaker		de Nierre	(Fire A Adiabate )	Own Ho	me		
Maryland	be fill H od ott	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame) Pearson			
⋛	d Mer mark mark	은	Douglas R. Evans  19a. Informant's Name/Relationship (Type	Print!	19h Mailir	ng Address (St				City or Town, Sta	ate Zin Con		
<u>∞</u>	tth an		John E. Frere / Hu							lexandri			4
Baltimore,	s 1 and 2 should be filed within 72 ho if Heelth and Mental Hygliene. Item 27 is marked other than "natur other traumatic event, the M. Clicial		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name o	f !			20c. Location - Cit			•
Ë	permit. Pages of Department of himportant: if ite any injury or of once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State				9/2	7/2006	Alexand	ria, V	Virgi	nia
<u>=</u>	mit. spartn sports ly inju		21. Signature of Funeral Service Licensee		5 22	Name and Acmorate Tr	dress of Facility	uner	al and	Crematio:	n Cent	ter	
m —	90E 9		eys. 4		10	40 Rock	ville P	ike;	Rockvi	lle, Mar	yland	2085	2
I			23a. Part1. Enjer the disease, or complice shock of heart failure. List only one Immediate Cause (Final		n. Do not ent	er the mode of	dying, such as o	cardiac or	respiratory arr	est,	Inte	proximate erval Betwe set and De	
ed.	Physician /Medical		disease or condition resulting in death)	Pulmona Due to (or as a consequence		Embol	(3 )-\						
	Examiner		Sequentially list conditions b										
	D iii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):				<i>h</i> /				
	be executed slcien and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):				)- 		-	<del>.</del>	
760,	yslcien yslcien ie buria	calE		, ,	,								
89			u.					135351	180000000000				
Box	death certifica e attending ph d for use as th	M/us	230. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		⊒Ectopic pregn	ancv			23d. Date of	_ ,		
	e deat he atti	Physician/Med	in the past 12 months? 1 ☐ Yes 2 MNo	4☐ Pregnant at time of de 9☐ Unknown		Other (specify				Month	Day	/ Yea	ar
o.	that the de led by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions contri	ributing to death but not rec	ulting in the u	nderhing cause	a awan in Part I		23e Did to	bacco use contribi	ite to the ca	ause of dea	ath?
ď,	8 50	d by	Part II. Other significant conditions conti	ibuting to death but not resi	aiting in the d	noonying cause	s given in raiti.				☐ Probably		
Hecords,	w require been si should t	lete				-			24a. Was a	ın 24b. We	re autopsy	findings av	railable
Ë	: The law cete has b page 2 s	Completed			-				autop: perfor	med? prid	or to comple th? Yes 2	tion of cau	se ol
Vital		0	25. Was case referred to medical				26. Place	of Death	1 ☐ Yes (Check only or		1105 2	) INO	
	ysician: nis certifice director, p	To B	examiner? 1 Yes 2 □ No	spital: 1 🗆 Inpatient 2	ER/Outpatier	nt 3□ DOA	Other: 4 Nur	rsing Hon	ne 5□Resid	ence 6 □Other	(Specify)		
0	ding Phy h. After thi funeral c		27. Manner of Oeath 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?		8d. Describe h	ow injury occurred			
Division of	ten deat tor; the	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place ol Injury - At ho	ome farm st		1 Yes 2 N		BL Location (S	treet and Number	or Rural Ro	ute Numbe	
<u>N</u>	tel or Attend s after death si Director; , sd in by the f	Certification:	4 Homicide determined	building, etc. (Specif	y)	1991, Tactory, on			City or Tow		or ribiar rio	otte reambe	п,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical		cian: To the best of my kno er: On the basis of examina and manner stated.									
	To the To the Comp	Me	29b. Signature and title of certifier	1/100 h.	0		cense number	/		29d. Date signed (			
	;		James K Ly	Jely 1	/	5	2326	)	<	Septembe	er 2	6,20	206
(	0		30. Name and address of person who com	apleted cause of death (Item	1 23a) (Type,	Print)	anna	. 1/	1.1	Septembe TAKOMA	0.0	20	912 MI
	Sta	ato.	31. Date filed (Month, Day, Year)	32. #egistrar's Signa	ture	1600	CARR	011	AVE.	IAMOMA	TAR	15,/	14.
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 3 20	06 Brown	ture	raves							

			1 - For State Registrar	State of	Maryland	/ Depa	artment rtificate	of H	ealth a	and M		jiene (	16	32896
100	Physici	an	1. Decedent's Name (First, Middle, Last								2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	cal	Elizabeth Estell		hasl		4h City T		Location o	f Dooth	Octobe	r 01 2	006	12:00 a <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution, give		Der)		40. City, 1		mins				arro	
	Funeral		Carroll Hospital 5. Social Security Number 6. Se	x 7	'. Age (In yrs. la:		If Under Months		If Under		8. Date of Birth (Month, Day	1		place (State or Foreign intry)
	Director		220 00 000.	□ M 2□ F	97	7 Yrs.	Months	Days	Hours	MIII.	Sept 0			MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Maryl -f ehc	ō	MD Carro	11	ı	New W	indsor	•						1 Yes 2 □ No
	n the	Director	10e. Street and Number				10f. Zip					0g. Citizen of V		intry?
	23a (23a (		227 Main Street						776			Ŭ	SA	
	er de	Funeral	11. Marital Status	Armed Fore		. 13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		e - Ameri ck, White,	ican Indian, , etc.
336	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Tes 2 If Yes, Give Year or Da			1 ☐ Yes 2	<b>⊠</b> No	Specify:			Specify	<i>i</i> : 1	White
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. I other then "natural", or itame 23a or 28a-f ehow event. The Medical Examinat must be notified at	ted	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usua kind of wor	Occupa	tion	t of worki	20	16b. Kind of Bu		
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	e retired)	uning most	OF WORK	<i>'9</i>	Woodsb Factor		Sewing
2	filed w Hygier other th	Co	7 17. Father's Name (First, Middle, Last)			Fac	ctory	Worl		r's Namo	(First, Middle,			
Maryland	0 7 5 P	To Be	Caleb Newton Wo	1fe							Ann Wi		16)	
Aar)	2 sh and le m		19a. Informant's Name/Relationship (T)				_		_		Route Number		·	p Code)
	1 and Health em 27 ther tr		Richard Wolfe/nep  20a. Method of Disposition	hew	20b. Pla						mar, MD	21757 20c. Location -		own State
nor	Pages nent of I int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ If		late		natory or ot							
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		Beave	22	2. Name and	Addres	s of Facilit	У		Union B		e, MD
ñ	Deg Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		I John X Al	4							and Ch			21157
	-		23a. Part. Enter the disease, or comp shock, or heart failure. List only of	lications that ca ne cause on ea	used the death.	Do not ent	er the mode	of dying	such as	cardiac o	r respiratory arr	est,	1,117	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Bo late	eral	1	heu	wr	ne			1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a conseque	ence of):	D	7	nor		1 .			
3),	<b>X</b> .	-	Sequentially list conditions,	b	or as a conseque	ance of):	Bowe	(	) us f	well	rin		-	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,								
o`	an and riat-tra		resulting in death) Last	Due to (c	r as a conseque	ence of):								
3760,	ate be executed hysician and the buriat-transit	licai	(	d										
∞ ×	ertifica ding pt	Physician/Med	IF FEMALE:	22a If was outs	ome of espanses									
Вох	at the death certif by the attending stached for use as	clany	in the past 12 months?	1 Live bir	ome of pregnand th 2 ☐ Fetal d int at time of dea	death 3	Ectopic pre					23d. Dat Mo	te of deliv nth	ery Day Year
o.	the di y the	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknov										
٥.	res that igned b be deta	by P	Part II. Other significant conditions co	ntributing to de	ath but not result	ting in the u	nderlying ca	use grve	n in Part I.		23e. Did to	bacco use cont	ribute to t	the cause of death?
ğ	w require been sig should b		- 200 Centr	ry l	aprati	om y					1 🗆 Y	es 2 No	3 Prol	bably 4 Unknown
Records,	e law re has be je 2 sho	Completed	(4113	of a	-dhes	in					24a. Was a	iv i i	orior to co	opsy findings available ompletion of cause of
	yaician: The Is certificate his director, page	Соп									1 Yes	ned?	death?	210 No
Ž	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
ō	Phys r this aral dia	. To	1 Yes 2 No 27. Manne f Death	28a. Date of	Injury 2	R/Outpatier 28b. Time o		Bc. Injury Work	4 🗀 Nu		ne 5 Reside			fy)
o	Attending Ph or death. octor: After th by the funeral	atior	1 ─ atural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	М		? ′es 2 ∐ i	No				
Division of Vital	To the Hospital or Attending Phyaician: The law requires that the death certificate be executed within 54 hours alter death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At hom g, etc. (Specify)	ne, farm, str	eet, factory,	office		2	28f. Location (S. City or Town	reet and Numb	er or Run	al Route Number,
	ors af ors af ors af ors or ors or ors or ors or ors or ors or or or or or or or or or or or or or o		CO. C. office and Co. office Physics	-1-1										
	Hos 24 ho Fund etely i	Medical	29a. Certifier 1 Certifying Phy (Cneck only one)	rsician: 10 the ba: iner: On the ba: and mann	sis of examination	n and/or in	n occurred a vestigation,	it the tim	e, date ani inion, deal	d place, a th occurre	and due to the c and at the time, d	ause(s) and ma ate and place,	nner as s and due t	stated. to the cause(s)
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Me	29b. Signature and title of certifier	. (			29c.	License	number		2	9d. Date signer	d (Month,	Day, Year)
	-1		Shusted	72	21		1	39.	502	H	0	lola	101	0
1	15/4		30. Name and address of person who co		of death (Item 2	23а) (Туре,	Print)	4.	1	<u></u>	1. m h	. 1	L	Day, Year)  O  M  M  T  T  T  T  T  T  T  T  T  T  T
	2		31. Date filed (Month, Day, Year)	4 h M	nietraria Sianatu	1/1/	-ast	Ila	in S	( ,	Wyll	erter		J 000 9
New York	Sta Registi		OCT 0 2 200	6 Sec	gistrar's Signatu	Spa	whe							

			For State Registrar	tate of Marylan	•	artment rtificate			ind M		giene 200	6 32897
	Dharatata		1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day Ye	3. Time of Death
	Physicia /Medic		Leta Diann Fegan								er 24, 20	06 8:10 A M
	Examin	er	4a. Facility Name (If not institution, give stre	et and number)		_	_	Location of	f Death		4c. County of D	
			1307 Mayo Road	7 Ago (In ura	lant hirthdayl	E of Under	dgewa	ater If Under 2	A Hre	B Date of Birth		e Arundel
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 44	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 3/7/19	(Year)	Birthplace (State or Foreign Country) hio
-		ŀ	402-11-8682 Usual Residence of Decedent	44						3/1/17	02	
	how in		10a. State 10b. County	10c. Cit	, Town or Lo	cation						10d. Inside City Limits
	ith the Marylar or 28e-f show	cto	Maryland Anne Arund	lel E	dgewat	er						1 ☐ Yes 2 ☐ No
	(i)	Director	10e. Street and Number			10f. Zip		_		1	Og. Citizen of What	t Country?
	a 23a		1307 Mayo Road	Was Decedent Ever in U.	C 12.1		2103		in? (Can	offu Voc or No.	USA	merican Indian,
	iter de	Funeral	TT. Marker Glado	Armed Forces?	3. 13.	f Yes, spec	ify Cubar	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)	Black, V	Vhite, etc.
	ours after death with the Maryla rei', or itema 23a or 28e-f shov Examinar must be mutified at	by	3 Widowed 4 Divorced	1 Mayes 2 □ No If Yes, Give Year or Dates: 1980-	-83	1 ☐ Yes 2	2∭ No	Specify:			Specify:	White
5	filed within 72 hours after death with the Maryland Hygiene, then "naturel", or itema 23s or 28e-f show ent, the Medical Examinar must be notified at	ted	15. Decedent's Educati (Specify only highest grade of	on	16a, Dece	dent's Usua	l Occupa	tion	of working	ng.	16b. Kind of Busine	ess/industry
7	thin 7	Completed		College (1-4or 5+)		kind of wor DO NOT us		uring most	Or WOTKIII	9	-	
7	ygien ygien it, the	Co	12th		Hom	emake		10 11-11-	d- N	(Final baidalla	Home	
	be fi	Be	17. Father's Name (First, Middle, Last)  Thomas Keith	. Doilor						Frances	Maiden Sumame)	
	d Me d Me mark	ဥ	19a. Informant's Name/Relationship (Type,		19h Mailir	nn Address	(Street a				r, City or Town, Stat	te Zin Code)
2	permit. Pages 1 and 2 should be filed within 72 hr Department of Heelin and Mental Hygiene. Important: if item 27 is marked other than "natur eny injury or other traumatic event, tra Medical ones.		James J. Fegan/ Hus							ter, MD		(a) 2.p 0000)
Ď.	f Hee item		20a. Method of Disposition		lace of Dispo emetery, cret	sition (Nam	ne of	1	D	ate	20c. Location - City	or Town, State
2	Page nent o int: ff iry or		1 ☐ Burial 2 X Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	as Cre				9-26-	-06	Edgewate:	r, MD
5	permit. Deperting Imports eny inju		21. Signature of Fymeral Service Licensee		22	. Name an	d Address	s of Facility	Geo	rge P.	Kalas Fun	eral Home
۵	8258		19 Ulle		2	973 S	olom	ons I	slan	d Rd. E	dgewater,	MD 21037
	_		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the deat cause on each line.	n. Donotent	er the mode	e of dying	, such as	cardiac oi	respiratory arr	est,	Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	Greast	C	900	CI					CIGHT YEARS
	/Medical Examiner		resouring in death)	Due to (or as a conseq	uence of):							
	1	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):							
	d d ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events  c.									
ĵ	en an irial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
000	cate be executed bhysicien and the burial-transit	dicai	d									
Ď :	ding p	/Mec	IF FEMALE:	If yes, outcome of pregna	no.							1
	etten for us	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pro					23d. Date of Month	Day Year
<b>j</b>	the d	Physician/Med	1  Yes 2  No 9  Unknown	9 Unknown	5401 5	_ Ottles (3p	y)					
_	es that the death certific igned by the ettending p be detached for use as t	by Pr	Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use contribut	e to the cause of death?
Ž	w require been sig should b									1 🗆 Y	es 2□No 3□	Probably 4 Onknown
נ נ	law re as be 2 sho	piet								24a. Was a autops		autopsy findings available to completion of cause of
_	Physician: The law r this certificete has t ral director, page 2 s	Completed								perfor	med 2 deatl	h?
	cian: ertific ector,	Be	25. Was case referred to medical examiner?	ited.			1 -		of Death	(Check only or	19)	
5	Physical direction	To	1 Yes 2 No Hose	1   Inpatient 2	ER/Outpatier 28b. Time of			4 🗆 1401			ence 6 Other (3	Specify)
5	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injury Work 1   Y	? ′es 2 🗆 N		00. D0301100 11	ow injury occurred	
2	Attan r deal octor	ertification;	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str	eet, factory	, office		2	8f. Location (S	treet and Number o	r Rural Route Number,
5	s efte ai Dir	Cert	4  Homicide determined	building, etc. (Specif	<i>(</i> )					City or Tow	n, State)	
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 6.2 hours elected to the this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Examiner	an: To the best of my kno : On the basis of examina	wledge, deat tion and/or in	h occurred vestigation,	at the time	e, date and inion, deat	d place, a	nd due to the c	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	thin 2 the 1 mplet	Med	ane) 29b. Signature and title di certifier	and manner stated.		290	License	number		2	9d. Date signed (M	onth. Dav. Year)
	F 3 F 8		11/ Wm	0					301	/	Spp team	ber 25,2006
	. 1		30. Name and address of person who comp	leted cause of death (Item	1 23a) (Type.			٠/.	701	-		/ -
	2+1		Kevin Knopf, M.D.	900 Bestg			00,	Annap	olis	, Marvl	and 21401	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2.7 2006	. Registrar's Signa		00						
			3FF / / / 1111D	and the second s								

			1_ For		ryland / De	partment of	Health and M	ental Hygi	ene .	20000
			Registrar		C	ertificate of	Death		2006	32898
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Maurice J. Floyd				S	2. Date of Death Month eptember	29, 2006	3. Time of Death 8:15 P. M
	Examir		4a. Facility Name (If not institution, give Homewood at Cruml.			4b. City, Town, Freder	or Location of Death ick		4c. County of Dear	
	Funeral Director		377-09-3791	7. Age	91 Yrs. last birthda	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, ) cember 2	9. 8in Cc 9, 1914 Te	thplace (State or Foreign buntry) Ennessee
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic	k	10c. City, Town or Jeffers					10d. Inside City Limits 1 ☐ Yes 2√ No
	with the A s or 28e-1	Direct	10e. Street and Number			10f. Zip Code	F	100	g. Citizen of What Co	ountry?
	s 23g	ral	3901 Shadywood C	12. Was Decedent E		2175		-W. Van as Na	USA 14. Race - Ame	dan India
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic avant, the Mudical Exata act must be multifued at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Xidowed 4 Divorced	Armed Forces?  1Yes 2 N If Yes, Give Year or Dates:		if Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto F Specify:	City fes of No- Rican, etc.)	Black, Whit	
Maryland 21215-0036	hin 72 ho s. an "netur Medicel I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	(Gi	cedent's Usual Occu ve kind of work done . DO NOT use retin	ipation o during most of workir ed)	ng 16	6b. Kind of Business	/Industry
2	d with	Om	12		Sale	sman			Life Insu	cance
/land	uld be file Mental Hy irked oth	To Be (	17. Father's Name (First, Middle, Last)  James Franklin F	loyd			18. Mother's Name Cleo Es	(First, Middle, Ma telle Co		
Man	alth and I		19a. Informant's Name/Relationship (Ty Richard Floyd - So:		1	-	od Court,		•	
nore,	ages 1 a ant of Hea it: If item y or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	L	position (Name of rematory or other pla n Memoria			oc. Location - City or rederick,	
Baltimore,	Departme Mportan Iny injur		21. Signature of Funeral Service Lie		1,-	22. Name and Addr	ess of Facility S	tauffer	Funeral Ho	ome
	402 4 4		23a Part 1 Enter the disease or complete	ications that caused						cyland 21702
Ī	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of tmmediate Cause (Final disease or condition resulting in death)	CARD	10 MYOP a consequence of):				31	Interval Between Onset and Death
	Examiner	er.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	)	a consequence of):					
	ite be executed sysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease on figury that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
68760	icate be e physiciar s the buris	cal	C.	d					4	
O. Box	The law requires that the death certificate tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	B Ectopic pregnand  Other (specify)	су		23d. Date of del Month	ivery Day Year
٥.	uires that the de signed by the a id be detached f	by	Part II. Other significant conditions con Hyps 7HY ROLD	_				23e. Did toba	cco use contribute to	
Vital Records,	ne law require has been si ge 2 should b	Completed	RENAL INJUF					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
<u>a</u>	Physicien: The la r this certificate has ral director, page 2							1 Yes 2€	No 1 ☐ Yes	2 No
Ž	sicier certif recto	Be .	25. Was case referred to medical examiner?	lospital: 1  Inpatie		0	26. Place of Death			
on of	fune fune	tlon: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	4 🗀 IVui Sirig Hoii	e 5	ce 6 Other (Special injury occurred	cify)
=	i Diffe	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, (Specify)			8f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
_	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medicel Exami	sicien: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	ime, date and place, a opinion, death occurre	nd due to the cau od at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Complex	Me	29b. Signature and title of certifier	n mb		29c. Licen	2 19 36	290	Date signed (Monte	h, Day, Year)
nX	M		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Typ	e, Print)	21936 dde, A	REDER	CR	21702
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 4 2		r's Signatur	Sperke	3.2 (			• ~

DHMH 17 Rev 1/2001

DO.D. 9/29/06

Maurice Flago

Timothy Patrick Fleshman

# Please Type or Print in Black Indelible Ink

		Registrar	ryiand / Depar <i>Cert</i>	ificate of L	Health and Me D <i>eath</i>	ntal Hygiene	200	16 2200
Physic Medical Exam			7.017			2. Date of D Month		3. Time of Death
- Zan Zan		TIMOTHY PATR 4a. Facility Name (if not institution, give street ar		SHMAN	City, Town, or Location	October	10, 2006 Year	0207 hrs
		10944 Bridlepath Circle	,		Waldorf	or Death	4c. County of De	eath
Funera Directo		Social Security Number     6. Sex	7. Age (In yrs. las	st birthday)		der 24Hrs. 8 Date of	Birth(MM/DD/YYYY) 9	Birthplace (State or
Directo	ļ	215-62-5827 1XXM 2	F 53	Yrs.	Months Days Hou	rs Min. 11/1		reign Country) WASH DC
any	ļ	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				
Maryland 28a-f show d at once.	5	MARYLAND CHARLES			WALDORF	,		10d Inside City Limits 1 Yes 2 XXNo
ith the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number		1	Of. Zip Code		10g. Citizen of What C	
ith the 23a or	a Di				20601		UNITED ST	CATES
leath w	Funeral	1 Never Married 2 Married Arme	Decedent Ever in U.S. d Forces?	13. Was E If Yes,	ecedent of Hispanic Or specify Cuban, Mexical	igin? ( Specify Yes or N n, Puerto Rican, etc.)	No- 14. Race - Am White, etc	erican Indian, Black,
after call; on	by Fi	3 Widowed 4 A Divorced If Yes, Give	Year	1 Y	s 2 X No specify	:	Specify:	WHITE
hours "natur	ted			6a. Decedent's	Usual Occupation (Give of working life, DO NOT	kind of work done	16b. Kind of Busines	
15-0036 Tiled within 72 hour Hygiene. d other than "natu the Medical Exan	Completed	12	e (1-4 or 5+)		C DRIVER	use retireu)		
5-0036 iled within 7 Hygiene. I other than the Medica	ပြ			11001		r's Name (First, Middle	, Maiden Surname)	TING
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural"; or items 23a or 28a-7 she mait's event, (be Medical Examiner must be notified at once	&	CECIL FLESHMAN  19a. Informant's Name/Relationship (Type, Print)			NOR	A CHRISTIN	E JONES	
and 2 shou lealth and 7 tem 27 is 1	ြို	JAMES L. FLESHMAN - BRO		19b. Mailing Ac	dress (Street and Nur	nber or Rural Route Nu	umber, City or Town, Sta	te, Zip Code)
Ore, MC es I and 2 s of Health at If item 27		20a Method of Disposition	20b. Plac	ce of Disposition	(Name of cemetery,	OCTOBER	20c. Location - City	
Baltimore, permit Pages I ar Department of Hee Important: If ite njury or other tr		1 Burial 2 X Cremation 3 Remove		matory or other p	*	11, 2006		MARYLAND
Baltimo permit Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee	M00053	22. Nam	and Address of Facility	.O.BOX	3035 OL	D WASHINGTON
Physician	-	23a. Part I. Enter the disease, or complications the	at caused the death. Do	IUUNI	I FUNERAL I	HOME: T	TOTALL OF	F, MD 20601
/Medical Examiner		, and and an additional			c cardiovascu		rest, shock, or heart	Approximate Interval Between Onset and
-xammer		or condition resulting in death)  Due to (or a	s a consequence of):	OXICIOLI	c cardiovascu	tar utsease		Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or a	s a consequence of);					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C	s a consequence of);					
cuted ind transit		events resulting in death) Last Due to (or a	s a consequence of);					
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDE	<sup>D</sup> #23a,27,perl	ME 0860	10/26/06 TT			
876 tificate ng phy as the t	-	23b. Was decedent pregnant in the	s, outcome of pregnance	су			23d. Date of deliver	у
. Box 68760, he death certificate by the attending physic hed for use as the bur	Physician	past 12 months:	gnant at time of death	2 Fetal de 5 Other	eath 3Ectopic (Specify)	pregnancy	Month	Day Year
The de by the tched f	Phy	Part II. Other significant conditions contributing	nown	ting as the second				
, P.O.	d b		to death but not leading	ting in the under	iying cause given in Pai		obacco use contribute to s 2 No 3 Pro	
of Vital Records, ag Physician: The law require the this certificate has been sineral director, page 2 should b	Completed		<u> </u>			24a Was		stopsy findings available
Reco	mo:						rmed? death?	completion of cause of
tal Rectian: The	Be	25. Was case referred to medical examiner?			26.Place of Death (	1 Yes Check only one)	2 No 1 Y	es 2 No
of Vi	리	1 Yes 2 No		Outpatient 3			Residence 6 🗸 Othe	r: Scene
on of ending P ath or: After he funcra	Certification:	1 Natural 5 Pending (Mo	te of Injury th, Day,Year)	o. Time of Injury	28c. Injury at Work?		now injury occurred	
Division tal or Attendi rs after death al Director: A	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Pla	ace of Injury - At home,	farm, street, fac	tory, office building, etc		Street and Number or Ru	ral Pouta Number City
Div ospital or hours afte meral Dii	- E	4 Homicide determined (Specification 29a. Certifier 4 Homicide determined (Specification 29a. Certifier 4 Homicide determined (Specification 29a. Certifier 4 Homicide determined (Specification 29a. Certifier 4 Homicide determined (Specification 29a. Certifier 4 Homicide determined (Specification 29a. Certifier 4 Homicide determined determined (Specification 29a. Certifier 4 Homicide determined	<i>(</i> )	_		or Town, S	tate)	rai Route Number, City
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basi	est of my knowledge, d	leath occurred a	the time, date and place	e, and due to the caus	e(s) and manner as star	led.
To To	₩.	29b. Signature and title of certifier	stated	- Trootigation, ii	29c. License number	urred at the time, date a		
		Theodor U K	-6/ 10 -	4.0	O.C.M.E.		29d Date signed (Moi	15
	t	30. Name and address of person who completed ca	use death (Item 23a)	•			-, -300	
(DB)	ate		ant Medical Exan	miner 111	Penn Street, Balt	imore, MD 21201		
Regist		OCT 1 2 2006 2	Elecus D	Apen	e		-	

State of Maryland / Department of Health and Mental Hygien 2006 32901 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 Physician Conrad Grunfelder Sept. 30, 2:45 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Dec. 25, 19 Bethesda 9. Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** 11XM 2□ F Director 1914 065-07-2020 Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b. County 10d, Inside City Limits r 28a-f show Show 1 Yes 2 No MD Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? el', or iteme 23a or Exeminer must be USA 20902 1706 Gridley Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married 1 XYes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942-46 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) John Hopkins 3 Applied Physics of Health and Mental Hygie I Item 27 Ie marked other r other traumatic event, II other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Berger Conrad Grunfelder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Gridley Lane, Silver Spring, MD 20902 Patricia Grunfelder / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State artment of ortant: If It Injury or o 1 
☐ Burial 2 
☐ Cremation 3 
☐ Removal from State Ò St. John's Cemetery Oct. 5, 2006 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses Kelard I Holes 500 University Blva., W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequenca of): Examiner CLOSTRIDIUM DIFFICILE COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) certificete has been signed by the erector, page 2 should be detached is 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed2 20 No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No ours efter death.

nerel Director: A
filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours e To the Funerel I completely filled Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier DO057124 za mn 1012106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 9715 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 3 2006

			1- State of N Registrar		artment of Health and rtificate of Death		ene 2006	32902
	Physicia	20	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month October		3. Time of Death
-4	/Medic	al		GIBLIN	4b. City, Town, or Location of De		4c. County of Death	10:41 A M
j.	Examin	er	4a. Facility Name (If not institution, give street and number FREDERICK MEMORIAL HOSPITZ		FREDERICK	74(11	FREDERICK	
	Funeral		5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M	Irs. 8. Date of Birth (Month, Day,	(ear) 9. Birth	place (State or Foreign ntry)
	Director		115-50-5583	46 Yrs.		JAN. 15,		ington,DC
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-fah	ctor	Maryland Howard	Mount	Airy			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?
	eath v		689 Ridge Road  11. Marital Status 12. Was Deceder	nt Ever in U.S. 13	21771 Was Decedent of Hispanic Origin?		United Sta	ates
0	r item	Funeral	Armed Forces  1 □ Never Married 2 □ Married 1 □ Yes 2 □	s? ₹No	If Yes, specify Cuban, Mexican, Pu	ierto Rican, etc.)	Black, White,	etc.
5-0036	urel', c	d by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates		1 ☐ Yes 2X No Specify:			i <b>t</b> e 
15-	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Insturel', or items 23a or 28a-f show shit the Macical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of t DO NOT use retired)	working	6b. Kind of Business/Ir	ndustry
212	d withi	mo	Elementary/Secondary (0-12) College (1-4o		o Technician / M	lechanic .	Auto Repai:	rs
<u>B</u>	al Hyg	Be	17. Father's Name (First, Middle, Last)		18. Mother's !	Name (First, Middle, Mi	aiden Sumame)	
Maryland 2121	J Meni J Meni narke	2	Thomas E. Giblin	10b Maili	Juli		hmeler City or Town State Zi	n Codel
<u>a</u> ≥	nd 2 st lth and 27 is r r traur		19a. Informant's Name/Relationship (Type, Print) Thomas J. Giblin / Son		O Crossfox Lane			
Ē,	of Heal		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		0c. Location - City or T	
altimore,	Page ment c ent: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Frederic	k Crematoyr 10/	04/2006 F		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Hygiene State Hygiene.  Depertment of Hygiene Hygiene.  Depertment Hygiene.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility			
	40200		23a. Part I. Epray the disease, or complications that caus	ed the death. Do not en	8 E. Ridgeville ter the mode of dying, such as care			Approximate
	Physician		shock, or heart failure. List only one cause on each Immediate cause (Final	tine.	<			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	as a consequence of):				
	Examiner	_	Sequentially list conditions, b. Due to local	as a consiguence of	UA			
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	P	enel Failure			
o	cate be executed obysicien and the burial-transit	Exa		is a consequence of):	Circo i silving			
8760,	ate be ohysici the bu	dicai	d					
× 6	that the death certific ed by the attending pl detached for use as t	Physician/Medi	IF FEMALE: 23c. If yes, outcom	ne of pregnancy	_ 15 <u>=</u>	2/441-36164	23d. Date of deliv	erv
. Box	death e atter	Iciar	in the past 12 months?  4 Pregnant	at time of death 5[	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	at the by the	Phys	9 ☐ Unknown					
rds,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Ď	Part II. Other significent conditions contributing to death	but not resulting in the c	underlying cause given in Part I.	23e. Did toba	acco use contribute to	
000	law re as bee 2 sho	Completed				24a. Was an autopsy	24b. Were autoprior to co	opsy findings available ompletion of cause of
<u> </u>	Physicien: The lav this certificete has al director, page 2	Com				perform	ed? death? □ No 1 □ Yes	
Vita Vita	Physicien: rthis certifice ral director, i	Be	25. Was case referred to medical examiner?		Othor	Death (Check only one		
ō	g Phys er this eral di	n: To	1 Yes 2 No 1 Date of Ir	jury 28b. Time o	nt 3 DOA 4 Nursin	g Home 5 Resider 28d. Describe hov		<i>'Y)</i>
io	Attending in death.	atio	2 Accident investigation	Jay Ye <i>ar)</i> Injury	M 1 Yes 2 No			
Division of Vital Records,	l or Attenation after death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, farm, st etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the besis and manner	of examination and/or in				
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)
)			5. h95am		B119674	070	10/3/06	
١	$O_f$		30. Name and address of person who completed cause o	f death (Item 23a) (Type	Print) 400 West Seve	nth St./ F	/ / rederick, N	D 21701
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 0 4 2006. 32. egi	strar's Signature				

Robert M

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 006 32903 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 12, 2006 **Physician** Greene 1:10 am <sup>™</sup> Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany 117 Mullen Street Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) AUG 6, 1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1√ M 2□ F МĎ Yrs 220-26-9703 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland ty Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21502 USA 117 Mullen Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1, ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ified within 73 I Hygiene. other than "n College (1-4or 5+) Elementary/Secondary (0-12) C&P Telephone 12 laborer is marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event RDS. 17. Father's Name (First, Middle, Last) Be Mary Catherine Greene Albert F. Greene 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
724 Fort Hill Road Swanton MD 21561 19a. Informant's Name/Relationship (Type, Print) Michael Greene 724 Fort Hill Road son 20b. Place of Disposition (Name of cometery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/16/2000 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature / Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760, 5 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan CAVA brovascular 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. D scribe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed case e of death (I = m 23a) ype, Print) 30. Name and address of person who y, Year) 31. Date filed (Month, Day, 32. Pegistrar's Signature State OCT 17 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Reg. NZ 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OCTOBER 02, 2006 FREDDIE LEWIS GASTON 7:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XX M 2□F Yrs. Director 70 579 46 0718 SOUTH CAROLINA JUNE 09, 1936 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itama 23a or 28e-f ahow the Medical Examinar must be notified at XXYes 2 No Director DC WASHINGTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2124 31ST STREET, SOUTHEAST 20020 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married XX Married XXYes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes XX No ģ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DISTRICT OF COLUMBIA Elementary/Secondary (0-12) College (1-4or 5+) DEPT. OF PARKS&RECR. 4 YRS. DC RECREATION SPECIALIST permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If itam 27 is marked oth any links of the traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN VIRGINIA GILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 31ST. STREET, SE MAUREEN GASTON / WIFE WASHINGTON, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 10/10/06 SUITLAND, MD 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL S FUNERAL HOME OF MARYLAND, INC. all 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part. Forter the it sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. METASTATIC LIVER CANCER /Medical Due to (or as a consequence of): Examiner b. HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4XXInknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 1 ☐ Yes XX No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ※X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After XX Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Layenti latel D 052586 10/2/06 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 JAYANTI PATEL, M.D. HOLY CROSS HOSPITAL 1500 FOREST GLEN RD. SILVER SPRING, MD 31. Date filed (Month, Day, Year)
OCT 0 4 2006

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32905 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Month 2312 PM Horwitz September Z7 Z006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 918 Birthplace (State or Foreign Country) **Funeral** Days 1 ★M 2 □ F Hours 88 Director 578-46-1925 ΜŇ Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits or other traumatic event, the Mudical Examiner must be notified at Maryland Montgomery Silver Spring 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? ŏ 14800 Pennfield Circle, # 409 20906 U. S. A. "naturel", or Items 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces() 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Medical Examination. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo þ Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kmd of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Food Chemist Food & Drug Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nathan Horwitz Jennie Solosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14800 Pennfield Circle, # 409, Silver Spring, Md. Selma G. Horwitz - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Mem. Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/1/2006 0 4 Donation 5 Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald 1091 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown . Whaley 124a. Was an 24b. Were autopsy findings available prior to completion of cause of death? atio autopsy performed? 1 ☐ Yes 2 ☑ No Emplysema 1 ☐ Yes 2 ☐ No After this certification, funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury after death. 1 Yes 2 No the within 24 hours after de To the Funerel Directo completely filled in by tr 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) certifier September 28, 2006 30 Name and add person who completed cause of death (Item 23a) (Type, Print) 20 MP 18109 NW 31. Date liled (Month, 32. Pegistrar's Signature State 2006 Registrar

		ľ	1 - For State Registrar		Marylar		artmen ertificat				ental Hy	giene Reg. No.	006	32906
	Physici /Medic		Decedent's Name (First, Middle JOHN LOWRY	e, Last) HILL							2. Date of De Month SEPTEMI	Day	Year 2006	3. Time of Death 9:30P M
	Examir		4a. Facility Name (If not institution RENALSSANCE GARD	•		ING		,	Location of	of Death		1	MONTGOME	
	Funeral Director		5. Social Security Number 578-20-3014	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 84	last birthday Yrs.	) If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Bir (Month, Da NOV • 30	th ly, Year)	9. Birth Cor OHI	nplace (State or Foreign untry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits
	Maryl	tor	MARYLAND PRINC	E GEORGE'S		LVER SP								1 ☐ Yes 2X☐ No
	with the	Funeral Director	10e. Street and Number 3152 GRACEFIELD RO	)AD #119			10f. Zip	Code 2090		· · · · · ·			on of What Co	
	death me 23	nerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		I. Race - Amer	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Madical Examinational by notified at	र्व	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	2 No		1 Yes, spec		Specify:	i, Puerto i	Hican, etc.)		Black, White pecify: WE	o, etc. IITE
2	"natur	eted	15. Deceden (Specify only highe	t's Education st grade completed)		(Giv	edent's Usua e kind ol wo	rk done d	urina most	t of workii	ng	16b. Kind	d of Business/l	ndustry
212	d withing glene. r than	Completed	Elementary/Secondary (0-12)	College (1- 4	4or 5+)		DO NOT us AL CONT					CON	STRUCTIC	N
Maryland 2121	be filed stal Hygi of other event,	Be	17. Father's Name (First, Middle,								(First, Middle	, Maiden Si	umame)	
aryle	should nd Men marke umatic	၉	JOSEPH HAMILI  19a. Informant's Name/Relations			19b. Mail	ing Address	(Street a			LOWRY  / Route Numb	er, City or 1	Town, State, Z	ip Code)
	1 and 2 Health a am 27 is		MARJORIE HILL -	WIFE		3152	GRACEFI	ELD R	OAD #	‡119 <b>,</b>	SILVER		, MD 209	
nore	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		naio	Place of Disp cometery, cre				D 20/05/	ate		ation - City or	
Baltimore,	permit. Pages 1 a Depertment of Hea Important: If Itam any injury or othe		4 □ Donation 5 □ Other (S 21. Signatura → Ineral Servica		I FA		2. Name an	d Addres	s of Facility	HINES	- RINAL	DI FUN	VILLE, M ERAL HOM G, MD 20	E, INC.
	00540		23a. Part1 Enter the disease, or	complications that ca	used the deat								G, FID 20	Approximate
	Physician /Medical		shook, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	END S	TAGE CHR		STRUCTI	VE PU	LMONAR	RY DIS	EASE		1	Interval Between Onset and Death 2 WEEKS
E	Examiner				or as a conseq	uence of):								
-	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a conseq	uence of):								
760,	ate be executed hysicien and the burial-transit		that initiated events resulting in death) Last	c. Due to (c	or as a conseq	uence of):								
6876	ficate by physic is the bi	edicai		d										
P.O. Box	he death certificate be executed the attending physicien and ched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta int at time of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp			<u></u>		230	d. Date of deli- Month	<i>r</i> ery Day Year
	law requires that the de: as been signed by the a 2 should be detached f	by	Part II. Other significant condition	ons contributing to dea	ath but not res	ulting in the u	underlying ca	ause give	n in Part I.		1			the cause of death?
Corc	w require been si should t	ieted									24a. Was	-		bably 4 X Unknown opsy findings available
E Re	The ste h page	Completed		<del></del>							auto	osy irmed?	prior to d death? 1 ☐ Yes	ompletion of cause of 2 No
Zi Zi	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	FD/0		0#=		-	(Check only o			
Division of Vital Records,	ding Ph h. After th funeral	tion: To	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date or (Month		28b. Time of Injury		8c. Injury Work	4 (Z)1 VUI	2	ne 5∐ Resi 8d. Describe l		Other (Spec	rfy)
DIVISI	<b>₽</b> # # # #	Certification:	3 Suicide 6 Could of determined	not be 28e. Place of	of Injury - At ho g, etc. (Specif	ome, farm, st					8f. Location (		Number or Rui	al Route Number,
	To the Hospital within 24 hours e To the Funeral C completely filled	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the texaminer: On the base	sis of examina	wledge, deat tion and/or in	th occurred investigation,	at the time in my op	e, date and inion, deal	d place, a h occurre	nd due to the	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifie		// 40		290	. License					signed (Month	
			30. Name and address of person	Method source	of death (Item	232\ (Tun-	Print	D004	3375			OCTO:	BER 2, 2	UU6
d	0+1		DR KAREN MERRITT, M	D 3110	GRACEFI	ELD ROA		VER S	PRING,	MD 2	0904			
2	Sta Registr		31. Date filed (Month, Day, Year)	3 2006 32. R	gistrar's Signa	ture	bode	•						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** October 1, 2006 Electa E.H. Higgins 2:45pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery | Months | Days | Hours | Min. | April 4,1913 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TF 93 Yrs. 289-16-3417 Director PA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. fnside City Limits th and Mental Hygiene. 27 is marked other then "natural", or Itema 23a or 28a-f show treumatic event, the Madical Examinar must be incilited at 1 ☐ Yes 2X No Completed by Funeral Director Montgomery Village Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19377 Keymar Way 20886 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Colfege (1-4or 5+) Elementary/Secondary (0-12) 12 Personnel Director Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Ford Widdowson Margaret Jane Lydick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if Item 27 is any injury or other tre William F. Holcomb / Son 19377 Keymar Way, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State October 2 9 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, VA Injury of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** Cancer months disease or condition resulting in death) Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to miniscrate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Hyportension, Coronary been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed2 2. No 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 ☐ Yes 2 ☑ No Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of fnjury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Priscella Cella Lergya\_mp P41794 october 2, 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) Priscilla Callahan-Lyon baitherburg, MD 911 Russell Avenue 31. Date filed (Month, Pay, Year) 2006 32. Pegistrar's Signature State Registrar

			State of Maryland / Department of Healt 1 - State Amend #5 Per FH F860 10/30/06 JH Certificate of Dea	th and M ath	lental Hyg	iene g. 200	16	32908
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h		3. Time of Death
	Physici /Medi		GEORGE ALFRED HOLLAND, SR.		Month Sept.	Day 27 2	Year 2006	2:57 P <sub>M</sub>
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locat		•	4c. County	of Death	
			Atlantic General Hospital Berlin		· - · · · · · · · · · · · · · · · · · ·		orces	
	Funeral		UD82 1024 2015 Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	Coun	
	Director		220-28- <del>0528</del> Usual Residence of Decedent		Dec. 18	, 1931	Mar	yland
	yland		10a. State 10b. County 10c. City, Town or Location				1/	0d. Inside City Limits
	e Ma Sa-fs	ctor	Maryland Worcester Berlin					1⊠Yes 2 No
	ith th	Director	10e. Street and Number 10f. Zip Code		1	0g. Citizen of V	/hat Coun	itry?
	s 23e	ra	205 Branch Street 21811			US		
	ter de itam iner	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent of Hispania If Yes, specify Cuban, Me:	c Origin? (Spe xican, Puerto	ecity Yes or No- Rican, etc.)		e - Amenc k, White, e	an Indian, etc.
036	urs al	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ X Yes 2 ☐ No 1950 − 1958 1 ☐ Yes 2 ☐ No Spe	ecify:		Specify	Blac	·k
5-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during	most of worki	na	16b. Kind of Bu		
2	ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	THOSE OF WORK	'ig			
5	Hygie Hygie ther th		12 laborer  17. Father's Name (First, Middle, Last) laborer	Aothoric Name	(First, Middle, A	Poultr		lustry
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "nature!", or Itams 23a or 28a-f show eumstic event, the Medical Evaninar must be notified at	o Be			Ellen Jar		7)	
<u> </u>	shoul nd Me mark	7 2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number 19b)				State. Zip	Code)
Ž	alth a alth a 27 ts		Albin Handy/ son 8046 Worcester H					
J.E.	of Her		20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)	D	ate	20c. Location -	City or To	wn, State
<u>Ĕ</u>	Pag ment ent: It ury o		1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  St. Paul UMC Cemeter	y 10/0	4/2006	Berlin,	Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natureli, or itams 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee)  22. Name and Address of F				Sali	
			Loute D. Mey JOLLEY MEM					21801
			23a. Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.		^			Approximate Interval Between Onset and Death
<b>O</b> i	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CHROWE OBSINGONE Vac	mont	reg 121	SEMSE		
9	Examiner		Due to (or as a consequence of):	OVO (A)	reg 1 di	D, C-1	18	
140	集	Jer	Sequentially list conditions, if any, leading to immediate cause. Einler Undertying	100112	LEEN / IL	- 01001		
2	cate be executed physician and the burial-transit	Examiner	that initiated events				1	
, 0	be executed ician and burial-transif		resulting in death) Last Due to (or as a consequence of):					
- /2	cate b physic the bi	dlcal	d					
% %	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy					
B B0	res that the death certifi igned by the attending I be detached for use as	Physician/Me	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date Mon	of deliver th	ry Day Year
2/20	the d by the	lsku	1  Yes 2  No 9 Unknown 9 Unknown					
S, P	requires that een signed b nould be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	art I.	23e. Did tob	acco use contri	bute to the	e cause of death?
₩ ords	w require been sig should b				1 🗖 🔞	s 2 🗆 No	3 🗌 Proba	ably 4 🗀 Unknown
v S	aw as b	Completed			24a. Was ar		/ere autop	osy findings available
300 0	The ate h page	Com			perform	ed? d	eath?	•
600 -052 Vital	cian: ertific	Be (	examiner?	Place of Death	(Check only one	)		
- 10 to	di S	To			ne 5 Resider			)
127 171	ding Ph h. After th funeral	tlon	1 Natural 5 □ Pending (Month, Day Year) Injury Work?		8d. Describe ho	w injury occurre	a	
Schol S 222-	or Attending after death. Director: After in by the fune	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory office		8f. Location (Str	eet and Numbe	r or Rural	Route Number.
220 Divisi	o fite	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)		
+0	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	e and place, a	nd due to the ca	use(s) and man	ner as sta	ated. the cause(s)
	To the I within 2. To the I complet	Medical	and manner stated.  29c. Signature and title of certifier  29c. License numb			d. Date signed		
	D D		Mucaco (ho) 1946	257	7	9/2	8/201	16
X	2,6	9	30 Name and address of person who completed cause of death (them 23a) (Type, Print)	/		1/20	1200	710
~ `	17		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  EDWIN CASPANEDA, MID 10324 020 OCE	Sulve	114 /3	VD.	403	(in, m)
	Sta Registr	ăc.	31. Date filed (Month, Day, Year)  OCT 0 3 2006  32. Registrar's Signature				4	011
			UU I U O CUUU   Florida oo o ( // COOLER)					

06-07271		Please Type or Print in Black Indelible Ink			
Jonathan Howard		State of Maryland / Department of Health and Mental F	łygiene	200	6 32909
Amended  * Pfiysicia	#_	Registrar 19a Per FH , gc10/4/06	2. Date of De	Reg No.	3. Time of Death
Medical Exami	111/	JONATHAN B. HOWARD	Month Septemb	per 26, 2006	2130 hrs
, <u>a</u> 2000-		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 21516 Rominger Court Lexington Park	th	4c County of Death St. Mary's	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24H	_	birth(MM/DD/YYYY) 9. Bir	thplace (State or on WASH.,
Director		578-04-6661 1XM 2 F 40 Yrs. Months Days Hours Mi			untry) DC
any	Í	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
* .					1 XYes 2 No
arylan	Director	MD         ST. MARY'S         LEXINGTON PARK           10e. Street and Number         10f. Zip Code		10g Citizen of What Cou	ntry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-fshow matie event, the Medical Examiner must be notified at once.		21516 ROMINGER COURT 20653		U.S.A	.4
h with	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (			ican Indian, Black,
or ite	Fun	1 Yes 2 X No	o rican, etc.)		A CIV
2 hours after de: "matural", or i I Examiner mu	ò	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: B1	ACK
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re			,
5-0036 led within 7 Hygiene. other than	Completed	12TH GRADE TECHNICIAN		COMCAS	Т
15-( filed v I Hygi ed oth				, Maiden Surname)	
imore, MD 21215-0036 Pages I and 2 Should be filed within 72 ment of Health and Montal Hygene rant: If item 27 is marked other than " or other traumatic event, the Medical	o Be	19a Informant's Name/Relationship (Type, Print )  Jacqueline  Jacqueline  Jacqueline	L SNE	エレ umber, City or Town, State	Zip Code) 0 6 5 3
MD d 2 sho lth and n 27 is numati		Jacqueline M. HOWARD-WIFE 21516 ROMINGER CO			
re, N s I and f Health If item er trau		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
altimore, mit. Pages lar partment of Hee portant: If ite		4 Donation 5 Other Specify: CEDAR HILL CEMETERY	0/5/06	SUITLAND	, MD
Baltimo permit. Pages Department of Important: I		21. Signature of Funeral Service Licensee 22. Name and Address of Facility P			
Physician	_	23a. Part I. Enter the disease, or complications that caused the deap Do not enter the mode of dying, such as cardiac	N. E.	WASH., DC	20002 Approximate Interval
Medical	9 7	failure. List only one cause on each line.	. ,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a CONTACT GUISINOT WOUND OF CREST  Due to (or as a consequence of):			
***	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
cecuted and transit		events resulting in death) Last Due to (or as a consequence of):			
e executed sian and ial - transi	lical	UNPENDED AMENDED			
68760, scriffcate by dding physics as the bur	cian/Medic	15 FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	
c 68	cian	250. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nancy	Month (	Day Year
Box e death c the atten	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ew After this certificate has been signed by the attending physician innertal director, page 2 should be detached for use as the burial.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to es 2 No 3 Prot	
ds, equire	Completed		24a Was		itopsy findings available
cor e law r e has b	m p			ormed? death?	completion of cause of
of Vital Records, ng Physician: The law requir Niter this certificate has been is meral director, page 2 should la	ပ္ပ	25. Was case referred to medical 26 Place of Death (Checi		2 No 1 Y	es 2 No
Vita Lysicia this ce direct	O B	examiner?  1 Ves 2 No  Hospital 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nurs	ing Home 5	Residence 6 🗸 Other	r. Scene
n of ding Ph	i.i	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d Describe Subject shi	how injury occurred	
Sior Attend death ctor:	catic	2 Accident Investigation			4000
Division pital or Attendi ours after death ceral Director: A	ertification:	3 Suicide 6 Could not be determined (Specify) Single Family	or Town,	(Street and Number or Ru State) ninger Court, Lexing	
12 S S T T	O	4 Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
To the Hos within 24 h To the Fu	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		. ,	
F » F ö	Me	29b Signature and title of certifier 29c. License number		29d Date signed (Mo	
119		Mbra Brasoll, M.D. O.C.M.E.		September 27, 2	006
90		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MI</li> </ol>	D 21201		
Ø (	ate				
Regist		31. Date filed (Month, Days Year)  OCT 0 4 2006  Slate: 32. Register's Sign			

			For State Registrar	State of	Maryland	l / Depa <i>Cer</i>	rtment of Hetificate of L	ealth a D <i>eath</i>	ind Mei		en <b>2</b> 0 0	6	32910
		7	1. Decedent's Name (First, Middl	9, Last)						Date of Death Month	Day	Yeer	3. Time of Death
	Physici /Medic		Louis D.	Hairston					Se	ept. 2	4, 200	)6	12:10 P <sup>M</sup>
1	Examin		4a. Facility Name (If not institution	-			4b. City, Town, or				4c. County of	f Death	
ji, a r	All Control of the Co	j.	Washington Adv		•		Takoma	Park If Under 2			Montgo		
HS	Funeral Director		5. Social Security Number 225-46-2015	6. Sex 7	. Age (In yrs. la:	st birthday) Yrs.	Months Days	Hours	Min. 8.	Date of Birth (Month, Day, Y	(ear)	Countr	ece (State or Foreign ry)
			Usual Residence of Decedent		00				- DC	14,	1737	VILE	ginia
	ylanc		10a. State 10b. County		10c. City,	Town or Lo	cation					10	d. Inside City Limits
	e Mai	ctor	D.C.		Wash	ingto	n						XXYes 2 □ No
	ith th	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of W.	hat Countr	y?
	eth w	rail	6713 14th St.,				20012				S.A.		
	er de	Funeral	11. Marita! Status	Armed Ford			Vas Decedent of His Yes, specify Cubar	spanic Orig n, Mexican,	in? (Specify Puerto Ric	/ Yes or No- an, etc.)		<ul> <li>Americal</li> <li>White, et</li> </ul>	
36	rs aft	by F	1 ☐ Never Married 2 ☼ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give		1	☐ Yes 2X No	Specify:			Specify:-	Black	
Ş	2 hou	ed	15. Deceden	t's Education		16a. Deced	lent's Usual Occupa	tion		16	Sb. Kind of Bus		
215	hin 73	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-	4or 5+)	(Give life. L	kind of work done d OO NOT use retired)	u <i>ring m</i> ost	of working				·
7	giene giene	Com	12th	ounogo (		Secu	rity Guar	d			Private	e	
p	be file tal Hy d oth	Be (	17. Father's Name (First, Middle,	Last)						irst, Middle, Ma	aiden Sumame	)	
<u>ya</u>	Ment Ment arked	To	unavailable							irston			
Maryland 21215-0036	2 shot and the m		19a. Informant's Name/Relations Francina Hubba				g Address (Street a 14th St.						
	l and lealth om 27			.ru/rrrenu	20h Bla		sition (Name of	, IN . W	Date				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be multiled at once.		20a. Method of Disposition  1 Burial 2 Cremation		tate cer	netary, cren	natory or other place	) !	10/5/	0.5	c. Location - C	•	
∄	it. Partmer		4 Donation 5 Other (S	Children of	Rive		Pk Crem  Name and Address	o of Equilib			iverda:		ld.
Ba	Depa Impo eny is		21. Signatura de la constanta della constanta de la constanta de la constanta de la constanta	5			6 Kennedy						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea								1	Approximate Interval Between
700	Physician		Immediate Cause (Final disease or condition	a	Sig	10 Fire	- 8ho Fins	CK	- 8	opsis			Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseque	ence of):	4-	2					
	Z	_	Sequentially list conditions,	b	r as a conseque	na	tun	for	oym	one	•		
	pe tist	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S TOX	r as a conseque	In Fa	Lost - 1	Fue	erelan	10me	M.		
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (o	r as a conseque	nce of):	une .		1	repar	y.		
8760,	cate be executed physicien and the burial-transit	dical		L d	Dac	ubr	tus u	lei	7				
68	ficate g phy as the	a)		u									
Вох	thet the death certificed by the attending properties as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnand		Ectopic pregnancy				23d. Date	of delivery	y
<u>.</u>	deat	sicla	in the past 12 months? 1 □ Yes 2 □ No		nt at time of dea		Other (specify)				Mont	h D	Day Year
P.O.	et fhe by th	hy	9 🗆 Unknown						-				
	se ge	by	Part II. Other significant conditi	ons contributing to dea	//	ling in the ur	iderlying cause give	n in Part I.	77				cause of death?
Vital Records,	w requir been si should l	ompieted	Sirioux	2	114	CC PE	309	20 4		1 🗆 Yes	2 <b>10</b> No 3	Probat	bly 4 ⊡Unknown
ec	ne law n has b ge 2 st	npie	Diasul	is Ma	uu					24a. Was an autopsy	24b. W	ere autops ior to com	sy findings available ptetion of cause of
<u>~</u>	: The	Co								performe 1 ☐ Yes 2	No 1	ath? Yes 2	!□ No
<u>≅</u>	hysician: The la his certificate has I director, page 2	Be	25. Was case referred to medica examiner?	Hospital:	/		Othe	-		heck only one)	ű.		
	Phys this ral dir	٠. ح	1 Yes 2 No	1 Pin 28a. Date of		R/Outpatien 28b. Time of	3 DOA	4   Nur		5 Resident			
on	ding h. After fune	tion	1 Aatural 5 Pendir 2 Accident investi	g (Month	, Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ N		. Doscribo non	injury occurre	•	
Division of	Atten deal octor	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	of Injury - At hom	ne, farm, stre	eet, factory, office			Location (Stre	et and Number	r or Rural i	Route Number,
á	al or s afte il Dire	Certification:	4 Homicide	buildin	g, etc. (Specify)					City or Town,	State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Certifier 1 Certifyin	g Physician: To the ba	ast of my knowl	ledge, death	occurred at the time	e, date and	place, and	due to the cau	se(s) and man	ner as stat	lod.
	in 24 in 24 ihe Fi	Medical	one) 2   Medical	Examiner: On the bas	or stated.	wi dilitator inv	estigation, in my op	mion, deat	occurred a				
-	To T To t	Σ	29b. Signature and title of certifie				29c. License	1 0.	/ -7	290	Date signed	(Month, Di	ay, Year)
7	1 =2			<b>\( \)</b>				118			7/24	106	•
4	#1		30. Name and profress of person	who tompleted cause	of death (Item 2	23а) (Туре,	Print)		00				D. 20852
	NE. JAN 1912		31. Date filed (Month, Day, Year)	ZUNIGA	- 470	1 7K	ANDOIP	HI	50.	Koah	0,112	m	D. 20852
45	Sta Registr		OCT 0 4 2006	Klave	gistrar's Signatu	porte							
	30	Y	ANI DE FOOD										

DHMH 17 Rev 1/2001

f. -

		1 - For State Registrar	State of Marylan		artmen rtificate					•g. NG. U	06	329	
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last,     Kenneth Dale Ha:     4e. Facility Name (If not institution, give)	rvey, Sr		4b. City,	To <b>wn</b> , or	Location of		Month Sept	26 2	Year 2006 y of Death	3. Time of 7:00	
Funeral Director		Gilchrest Cente 5. Social Security Number 215-34-6165	_	last birthday) Yrs.	If Under Months	Tow 1 Year Days	SON If Under 24 Hours	4 Hrs. 8 Min.	. Date of Birth (Month, Day March	Ba 6 1932	9. Birth	place (State o	or Foreig
ter deeth with the Maryland tems 23a or 28e-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  MD Carrol		y, Town or Lo Westm	inste							10d. Inside Ci	-
a 23a or 2 nunt be n	rai Dir	10e. Street and Number 48 Madison Stree				2115					SA		
E 2 3	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origi n, Mexican, Specity:	in? (Specif Puerto Ric	fy Yes or No- can, etc.)		ick, White	can Indian, etc. hite	
within 72 ene. than na	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us er/Tr	k done d e retired,	uring most o			K.D. I	Harve	У	
should be filed ind Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William Reading  19a. Informant's Name/Relationship (Ty		19h Mailir	ng Addrass	(Street a	El:	izabe	th S.	Maiden Suma Pierce , City or Town		Code)	
Health ar Health ar em 27 is ther treu		Jacqueline Fyler/D  20a. Method of Disposition  1 Bunal 2 Scremation 3 GF	aughter		Dreat	m Mi	nt Way		stmins	ter, M 20c. Location	21	157	
permit. Pages Department of I Important: If it eny injury or o		4 Donation 5 Other (Specify)  21. Signature of eral Se Lice		P.	ritts	fun	eratility	Home	and Ch	6 Ham apel, l inster	P.A.	d, MD 21157	
hysician /Medical examiner put using price	cal Examiner	23a. Part1. Entel the divase, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the course on each line.  Due to (or as a consequence of the course o	uence of):	er the mode			ardiac or r	espiratory arr	est,		Approximat Interval Beb Onset and I	ween
e attending phy	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pre					l l	ate of deliv		/ear
es been signed by th 2 should be detache	ed by Ph	Part II. Other significant conditions con	ntributing to death but not res		nderlying ca	use give	n in Part I.			pacco use con es 2 No			-
ate h page	e Completed by	25. Was case referred to medical						_	24a. Was a autops perform	ned? 2 ⊠ No	prior to co death?	opsy findings a mpletion of ca 2 No	availab ause of
ter this	To B	avaminar?	lospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nurs	sing Home		ence 6 (200th ow injury occur		n hosp	in
rs after death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory,	, office		28f	f. Location (St City or Town	reet and Numi n, State)	ber or Rura	al Route Num	ber,
within 24 hours after To the Funeral Directory completely filled in E	ledical	(Check only 2 Medical Examination)	sician. To the best of my kno ner: On the basis of examina and manner stated.	wiedga daail tion and/or in	vestigation,	in my op	inion, death	plane and occurred	at the time, d	ate and place,	and due to	the cause(s	)
MQL FF F	×	29b. Signature and title of certifier	NS		I	License ) 5 2	number		1	Septem	•		XX6
1		30. Name and address of person who co	555 W. 70	t mch		B(V)	) T	DWSON	1, m	2120	Ŷ		
Sta Registi	ate rar	31. Date filed (Month, Day, Year) SEP 2 9 2	32. Redistrar's Signa	ture	book	,							

			1 - For State Registrar	State of	Marylan	-	artment rtificate				lental Hyg	0 /	006	32912
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea	ith		3. Time of Death
	Physici /Medi		Margaret Kath	erine Heib	erger						Octobe	r 3	2006	5:00 P M
	Examir		4a. Facility Name (If not institutio	n, give street and num	iber)		4b. City, T	own, or	Location o	of Death		4c. C	ounty of Death	
			Ravenwood Lut					erst				V	lashing	ton
	Funeral		5. Social Security Number	6. Sex 1  M 2  F	7. Age (In yrs. i	* -	If Under 1 Months		If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign intry)
	Director		220-10-3524 Usual Residence of Decedent		88	Yrs.					Feb. 9	1918		land
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation	•						10d. Inside City Limits
	Marylan -fehow Ilan	to	Maryland Washi	ngton		Hager	etown							1X Yes 2 No
	r 28g	irec	10e. Street and Number			nager	10f. Zip C	Code			1	l0g. Citize	n of What Cou	intry?
	th with	Funeral Director	929 Frederick S	treet			217	40				US	A	
	dea	ner	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Decede	nt of His	panic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14	. Race - Ameri	
98	or It	F	1 ☐ Never Married 2 ☐ Mar	ned 1 ☐ Yes	2 🛣 No	1	1 ☐ Yes 2		Specify:	i, Fuerto	nicari, etc.)		Black, White,	etc.
8	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dital Evander froughter recitified at	d by	3 X Widowed 4 □ Divorced	Year or Da	tes:									ite
21215-0036	"nat	Completed		it's Education st grade completed)		16a. Deced	dent's Usual kind of work DO NOT use	done du	tion <i>uring m</i> ost	t of worki	ng	16b. Kind	of Business/In	dustry
12	withi	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		memake					Har	own ho	nm a
b	Hyg other ent,	BeC	17. Father's Name (First, Middle,			110	iire iira ice		18. Mothe	r's Name	(First, Middle, i			me
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-1 ehow amy injury or other traumatic event, tra Medical Evant actions the routilised any injury or other traumatic event.	To B	John David Rowl	and.					Kath	nerin	ne Easto	n		
ary	short and N s ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (	Street ar	nd Numbe	r or Rura	l Route Number	City or T	own, State, Zip	c Code)
	and a ealth n 27 i		Richard E. Heib	erger - Sc	n	107	27 Cli	nto	n Ave	nue,	Hagers	town	, Md. 2	1740
Baltimore,	of He		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Pamoval from 9	1 0	lace of Dispo emetery, crer	sition (Name natory or oth	of er place	)	C	ate	20c. Loca	tion - City or Te	own, State
Ë	Pages ment of ant: If It ury or o		'4 Donation 5 Other (5			se Hil	1 Ceme	tery	y   1	0/6/	06	Hagei	stown,	Md. 21740
3alt	permit. Departn Imports any inju		21. Signature of Funeral Service	Licensee			. Name and				linnich			
	70 = 4 0		Ined LIV	estal							Hagers		, Md. 2	1740
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death chiline.	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,	<	Approximate Interval Between Onset and Death
	Physician (Madies)		Immediate Cause (Final disease or condition resulting in death)	a	rever	re	Slu	Le	del	me	utra	w	the	Oriset and Death
	/Medical Examiner		rodaling in doding	Due to (d	r as a consequ	uence of):	Cond	1	o bal	L				
		P.	Sequentially list conditions if any, leading to immediate	b. Due to (c	ra a conseo	ence of):	1040	74	27.0					
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	-F	ache	unic	hea	بإزر	di	se	age			
Ć.	execute and and ial-tra	Exa	resulting in death) Last	c. Due to (c	r as a consequ	uence of):	Ti	_						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d	elvu	ne	opla	5/0						
9	ng ph	Med	IF FEMALE:	-			V					-		
Вох	death certifica attending ph of or use as the	an/	23b. Was decedent pregnant	23c. If yes, outc 1☐Live bir	ome of pregnar th 2 □ Fetal		Ectopic preg	inancy				230	. Date of delive	- /
O. E	the at the defined	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of de		Other (spec						Month	Day Year
P.(	that the died by the detached	Phy	Part II. Other significant condition	one contribution to do	th but not soon	ultina in the	adaah ina aas		in Danil		22a Did tak			ha a a sua a a falla a da C
ds,	S C 0	Completed by	Tarris, out of significant contains	one contributing to dea	iui but not resu	inting in the dr	idenying cau	za čisai	тыт гал. г.			s 2 $\square$ N		he cause of death?
Ö	w require been si	etec												
Record	has ge 2	mpi		<del></del>							24a. Was ar autops perforn	v	4b. Were auto prior to co death?	psy findings available impletion of cause of
_		e Co	25. Was case referred to medical								1 ☐ Yes 2	100	1 🗆 Yes	2 NO
Vital		m	examiner?	Hospital	patient 2 🗆 E	ER/Outpatien	t 3□ DOA	Other	-/		(Check only on		10.1 (0 II	
	ig Physter this neral di	n; To	27. Manner of Death	28a. Date of	Injury	28b. Time of		. Injury a Work?		-	ne 5 Reside 8d. Describe ho			/)
ion	는 · 누 5	atio	1 ☐ Matural 5 ☐ Pendin 2 ☐ Accident investi	y ·	, Day Year)	Injury	М		, es 2□N	No .				
Division	l or Attand after death Diractor: /	Certification;	3 ☐ Suicide 6 ☐ Could determ	ined 280. Place o	of Injury - At hor	me, farm, stre	eet, factory, o	ffice		2			lumber or Rura	al Route Number,
۵	spital or A ours after varal Dira filled in by	Ceri		building	y, etc. ( <i>apechy</i> )					į.	City or Town	, 3(8(8)		
	To the Hospital of within 24 hours af To the Funaral D completely filled in	edicai	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manner	est of my know is of examinati	wledge, death ion and/or inv	occurred at estigation, in	the time my opir	, date and nion, deatl	d place, a h occurre	nd due to the ca	iuse(s) and ite and pla	d manner as stace, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifie	/			29c. L	icense i	number		29	d. Date s	igned (Month,	Day, Year)
)	, ,		ten	the _		W.D	1	)60	411	131		ON	. 5,	2006
			30. Name and a dress of per in	who completed caus	of o ath (Item	23a) (Type, I	Print)		4)					
51	1-4		JETTY	L. COFF	ECES	, en-	$D \cdot l$	124	r Ol	AL	CT. K	tacqu	51-5TO	WN,
	Sta		31. Date filed (Month, Day, Year)	6 2006 32. Re	istrar's Signati	ute M A	1 1/1						mp	Day, Year)  2006  SWN 4
5	Registr	aı	001 0	0 2000	recor ,	U. Sty	and the same							

			For State Registrar	State of Ma		artment rtificate			and M	lental Hy	gien, Reg. N	200	16	329	13
			1. Decedent's Name (First, Middle, Last	)						2. Date of De			V	3. Time o	f Death
	Physici /Medi		William Chelsea H	leatley						Septem	ber	<sup>25</sup> ,	2006	6:14	$A^{M}$
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or	Location o	of Death		4	c. County	of Death		
100			Heartfield Assist	ed Living	_	Bowie					I	Princ	ce Ge	orges	
	Funeral	(80	5. Social Security Number 6. Se	x 7. Age M 2□F	(In yrs. last birthday)	If Under 1 Months (	Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da 06/08/	th y, Year	)	9. Birthp	place (State	or Foreign
	Director		216-40-9887	IM ZUF	82 Yrs.					06/08/	1924	+	Scot		
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation							1	10d. Inside C	City Limits
	Aaryll	٥	Maryland Prince G		Bowie										2 No
	28a-	Director	10e. Street and Number	reorges	Bowle	10f. Zip C	ode				10a. C	itizen of \	What Cour	ntry?	
	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23s or 28s-f show na Madleal Examinar must be recitified at	0	7904 Quatrefoil Co	urt		2072					USA			, .	
	ne 23	Completed by Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.			spanic Orio	gin? (Spe	ecify Yes or No			e - Americ	can Indian,	
(0	ritter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗘 No					, Puerto	ecify Yes or No Rican, etc.)			ck, White,	etc.	
03	el', o	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2X	J No	Specify:				Specify	Whi	te	
21215-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual (	Occupat	tion	t of worki	na	16b. l	Kind of B	usiness/In	dustry	
21	thin le.	pigu	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use	retired)			,,,,	Arc	chite	ctur	a1	
	ed wi	Sol		4	Elect	rical						ginee			
nd	tal H d off	Be	17. Father's Name (First, Middle, Last)							(First, Middle			ne)		
χ	ould Men Marke Marke	၉	William Heatley				-			shorn J					
Maryland	2 sh and le rr		19a. Informant's Name/Relationship (7)			-				Il Route Numb	-			(Code)	
	1 and Health im 27		Susan Critchfield/ 20a. Method of Disposition	Daughter	7904 20b. Place of Dispo	`		T COU		Bowie,				own, State	
Baltimore,	t of H		1 ☐ Burial 2 🛣 Cremation 3 ☐ F		cemetery, crea	matory or other	er place			100			•		
ŧΪ	t. Pa rtmer rtant		4 Donation 5 Other (Specify)		Huntt Cr		~			′2006			, MD		• •
Bal	permit. Pages 1 and 2 should be ified within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show with Injury or other treumatic event, the Madical Examinat must be notified at ances.	n	21. Signature of Funeral Service Licens	:ee						ert E. id Bowi				ar non	iie
-			23a. Part1. Enter the disease, or comp	lications that caused the								ш 20	,,15	Approxima	to
8760,	Physician /Medical Examiner and the private an	I Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a c.	consequence of):	to	1th	rue	a e					Interval Bei Onset and	Death
Box 6	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	d	Fetal death 3	Ectopic preg							te of delive	,	Year .
P.O.	res that the digned by the be detached	Y Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cau	ise giver	n in Part I.		23e. Did 1	obacco	use cont	ribute to th	he cause of	death?
Division of Vital Records,	uires n sign	d by								1 🗀	Yes 2	2 🗆 No	3 Prob	ably 4	Ünknown
00	w requir been si should	Completed								24a. Was	an	24h. 1	Were auto	onsy findings	available
Re	he la e has ige 2	mg								auto	psy rmed?		death?	psy findings impletion of o	cause of
a	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical					OC Blace	of Dooth	1 Yes	2 X N	0	1 🗌 Yes	2 L No	
5	Physician: this certific ral director,	To Be	examiner?	Hospital:	2 🖺 ER/Outpatier	nt 3 DOA	Other			me 5 ☐ Resi		e <b>V</b> ion	er (Specif	Aes.	lines
o	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day			: Injury Work			28d. Describe				W 1133	may
ion	nding I ath. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Montin, Day	rear) Injury	М		es 2 □!	No						,
Vis	after death. Director: A	ific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str	eet, factory, o	office			28f. Location ( City or To			er or Rura	Il Route Nun	n <i>ber</i> ,
Ö	s aft el Dii	Certification:		banding, oter	(Spoonly)					ony or 10	www, ciui	.0)			
	tospl t hour uner		(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	my knowledge, deat	n occurred at	the time	e, date an	d place, a	and due to the	cause(	s) and ma	anner as s	tated.	s)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	one)	and manner state	d.									`	-,
	To To	-	29b. Signature and title of certifier			29c	icense	number	0		290. D	ate signe	a (Month,	Day, Year)	
							リ	) (	) di			110	XO.	UP:	21401
100	Sta	ate.	30. Name and address of person who co	ompleted cause of dea	0000	Rido	Kh	M	1et	1281	AV	Ma	poli	smo	

	1 For State Registrer	ate of Maryland / Depa <i>Cei</i>	artment of Health and I tificate of Death		2006	32914
Physician	1. Decedent's Name (First, Middle, Last) Richard Thomas Hawki	ns		2. Date of Death Month October	Day 2006	3. Time of Death 12:30 P M
/Medical Examiner	4a. Facility Name (If not institution, give street Kline Hospice House	and number)	4b. City, Town, or Location of Death Mount Airy		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 6. Sex 1 ☑ M	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Feb. 21,	ear) Count	ace (State or Foreign ry) h Carolina
Aaryland F show	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo			10	od. Inside City Limits
with the Mar a or 28a-f s Les notifies		FIEC	lerick 10f. Zip Code	10g	. Citizen of What Count	•
be filed within 72 hours after death with the Maryland lat Hygiene.  d other than "natural" or items 23a or 28a-f show event, the Mudical Energia erroat the rediffed at the Commission of Finneral Director.	17.34 Dogwood Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	med Forces? ☑Yes 2 ☐ No 1980—	21701 Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	United Sta  14. Race - America Black, White, e	n Indian,
be filed within 72 hou tall Hygiene. d other than "natura went, the Musical Baccompleted"	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	opleted) 16a. Dece (Give iife.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	b, Kind of Business/Ind	ustry
be filed v tat Hygie d other t		Electi	rical Maintenance 18. Mother's Nar	Engineer F ne (First, Middle, Mai		ors
d Menta	Donald Clisby Hawkins		Mary E1	izabeth W		Codel
nd 2 st alth and 27 is n ir traun	19a. Informant's Name/Relationship (Type, P David Horwitz / Broth	· ·	Dartha Dr., Dalla	•		Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enty injury or other traumatic event, III M. 2006.	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	/ai from State	natory or other place) Octo	ber 3,	c. Location - City or Tov cederick, M	
permit. F Departmit Importar eny injur	21. Signature of Euroral Service Lin nsee		2. Name and Address of Facility Sthaven Funeral S			
Physician /Medical Examiner	resulting in death)	ns that caused the death. Do not ent		or respiratory arrest		Approximate Interval Between Onset and Death
cate be executed only sician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):  Due to (or as a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician in by the funeral director; page 2 should be detached for use as it Medical Certification: To Be Completed by Physician/Medical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy ] Other (specify)		23d. Date of deliver Month	y Day Year
uires that I	Part II. Other significant conditions contribu	ting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
n: The law requiring the has been stronged as the conficution of the confidence of the completed and the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the complete of the comp	\ <u> </u>			24a. Was an autopsy performe	d? prior to com death?	sy findings available apletion of cause of
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2 Medical Certification: To Be Comp	1 Yes 2 No	iaf: 1 Inpatient 2 ER/Outpatier ia. Date of Injury (Month, Day Year) 28b. Time o	ott 3 DOA Other: 4 Nursing H	lome 5 Residence 28d. Describe how	ce 6 XOther (Specify, injury occurred	Hospice
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ie. Place of fnjury · At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
he Hospit in 24 hours he Funers pletely fille		n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.				
To the vithin To the comple	29b. Signature and title of certifier	ner M.D	29c. License number		Date signed (Month, C)	•
IDHIVA	30. Name and address of person who comple Michael Lerner, M.D.	ted cause of death (Item 23a) (Type,	Print)			,
State Registrar	31. Date filed (Month Oction) 4 200	32. Restrar's Signature	Cooks			

			_ For	State of		d / Departn	nent of H	leaith and M	-	giene		
			1 - State Registrar			Certifi	cate of	Death		Reg. No.	105	32915
	hysicia /Medic	al		rdon H	adda				2. Date of De Month	or a	1006	3. Time of Death 0/58 M
	xamin	er	4a. Facility Name (If not institution	give street and num ospital	iber)		Easto,	r Location of Death			ity of Death	1
Fu	neral	-	Mcmorial H 5. Social Security Number		7. Age (In yrs. la	st birthday) If l	Jnder 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	160+ 9. Birth	place (State or Foreign
Dir	ector		218-16-5870 Usual Residence of Decedent	1 <b>X</b> M 2□F	83	Yrs. Mo	nths Days	Hours Min.	02/06/	ay, Year)	MD	intry)
ıryian	Mou.	_	10a. State 10b. County		10c. City	Town or Location	n					10d. Inside City Limits
death with the Maryland	important; it tem 27 is marked other then inautar, or teme 23s or 28s-1 enow eny injury or other traumatic event, the Modical Examinar must be notified at once.	Director	MD QUEEN A	ANNE'S	GRAS	ONVILLE	of. Zip Code			10g. Citizen o	f What Cou	1 ☐ Yes 2 <b>X</b> No intry?
÷ ÷	ust to	ral D	107 PERRY CORNEL	R_ROAD		2	1638			USA		
er de		Funeral	11. Marital Status	Armed For		3. 13. Was I	Decedent of H , specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecrfy Yes or No Rican, etc.)	o- 14. R	ace - Ameri lack, White,	
)36 Irs aft	A DE	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🏋 Divorced	ed 1 XYes If Yes, Give Year or Da	2 ∐ No e tes:	1 🗆 Y	es 2 No	Specify:		Spec		-
Aaddaway, Thomas Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene	ical E	ted	15. Decedent	s Education		16a. Decedent's	Usual Occup	ation		16b. Kind of		HITE ndustry
£ 22 %	Pag.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life. DO N	of work done o OT use retired	during most of work f)	ang			
d 21 Hygier	4		12			STEAM FI	TTER			PLUMB		HEATING
and the state of t	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Be	17. Father's Name (First, Middle, L FRANK HADDAWAY	.ast)				18. Mother's Nam		, Maiden Suma	ame)	
aryla should	matic	ဥ	19a. Informant's Name/Relationsh	io (Type, Print)		19h Mailing Ad	dress (Street	EDNA WRI		or City or Tow	m State Zin	Cadal
Na Na	rtrau		LAWRENCE HADDAWA					E, BALTIM		-	n, State, Zij	/ Code/
Saldauay Baltimore, Mary Permit. Pages 1 and 2 sho Department of Health and 1	oth		20a. Method of Disposition		20b. Pla	ace of Disposition metery, crematory	(Name of		Date	20c. Location	n - City or To	own, State
im Page	in you		1 ☐ Burial 2 <b>X</b> Cremation 4 ☐ Donation 5 ☐ Other (Sp		late			ON 10/0	5/2006	STEVENS	VTIIF	· MID
alt Salt	eny inj		21. Signature of Funeral Service L	icasee		22 Nan	ne and Addres	ss of Facility	2000			HOME, P.A.
2 m go:	<b>8</b> a		16 t All	L'		106	SHAMRO	CK RD., C	HESTER,	MD 216	619	IOHE, P.A.
Phys	ician		23a. htt. Enter the dise shock, or heart failur. List of Immediate Cause (Final disease or condition			Do not enter the			or respiratory a	rrest,		Approximate Interval Between Onset and Death
	dical niner		resulting in death)		or as a conseque							v v
		_	Sequentially list conditions		201AC	ARRI	53T					24
pet	usit	nlne	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C A	⊷∩	anca or):						YRS
760, e be executed	e burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (d	r as a conseque	ence of):						(12)
	e bui	ca		d. AC	RTIC	STEN	750					Yrs
Division of Vital Records, P.O. Box 68 for Attending Physicien: The law requires that the death certifical after death.	use as th	by Physician/Medi	IF FEMALE:						-		300 7	
BO)	for use as	an	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal o	death 3 ⊟Ector	pic pregnancy				ate of delive	ery Day Year
O 2 5	tached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of dea vn	ath 5∐ Othe	er (specify)					- 4,
That	detac	y P	Part II. Other significant condition	s contributing to dea	ath but not resul	ting in the underly	ing cause give	en in Part I.	23e. Did t	obacco use co	ntribute lo th	he cause of death?
rds quires	should be	D D							10	Yes 2 No	3 🗌 Prob	ably 4 Unknown
aw re	2 sho	Completed							24a. Was		. Were auto	ppsy findings available
al Be	page	E							autor perfo 1 ☐ Yes	ormed?/	prior to cor death? 1 🗌 Yes	mpletion of cause of 2□ No
Vita vicien:		Re	25. Was case referred to medical examiner?		_			26. Place of Deat				
of \	2	<u>∘</u>	1 ☐ Yes 2 ☑ No			R/Outpatient 3[		4 Livursing no				y)
On O	j jo	o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Day Year)	28b. Time of Injury M	28c. Injury Work	at ?? /es 2 □ No	28d. Describe I	now injury occu	ırred	
VISION Street	y the	Eg	2 Accident investigation inves	ot be	of Injury - At hom	ne, farm, street, fa			28f Location (	Street and Num	ther or Rura	N Route Number.
Div after	d ii b	Certification;	4 Homicide determin	building	g, etc. (Specify)	10, 14111, 311001, 10	iciory, omce		City or To		Der or Flura	r rioute Number,
Division  To the Hospital or Attendin within 24 hours after death.	letely fille	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the base xaminer: On the base and manner	is of examination	ledge, death occu on and/or investiga	irred at the tim ation, in my op	e, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and m	nanner as st	lated. o the cause(s)
To the within 2	dwoo	S E	29b. Signature and title of certifier	0	1		29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			· AIL	Condi	$\mathcal{N}$		H 414	16		10/2/0	6 07	146
			30. Name and ress of person w	no completed cause	of death (Item 2	23a) (Type, Print)		_	1			
			John Londit			airel Co	nrt,	Eastor	, MD	216	01	
B	State egistra		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	re						
1	Siette			3 7005	1801811	Dr. Ga	reals.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BEATRICE HEADLEY October 2, 2006 2:00 P J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Somerset Crisfield If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F Director 9, 217-01-4663 88 June 1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be multified at 10c. City. Town or Location 10d. Inside City Limits XYes 2 □ No Completed by Funeral Director Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 434 Charlotte Avenue 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Soecify. White Specify: 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementary/Secondary (0-12) College (1-4or 5+) 8 Manufacturer Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Mark Harrison Madge Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Wynfall Avenue - Crisfield, Maryland 21817 Oliver Lawson (Son) othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. ō 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park October 5, 2006 Crisfield, Maryland 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) SCVD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2X No 2 No 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Momicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 48098 10/02/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijoy Korumounathan, M.D. - 201 Hall Highway - Cristield, Maryland 21817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

		•	For State Registrar	State of Marylan	d / Depa	artment of Hertificate of D	ealth and N	Mental Hygi	ene 006	32917
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)  William A  4a. Facility Name (If not institution, give seconds)			4b. City, Town, or I	ocation of Death		Day Year 1, 2006 4c. County of Dea	3. Time of Death 0130 M
	Funeral Director	iei	6033 Clevelandtow 5. Social Security Number 6. Secu	n Road	last birthday) Yrs.		oro If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, sept 12)	Washir (ear) 9. Bir 2006	ngton thplace (State or Foreign buntry) MD
	he Maryland 8a-f show	Director	10a. State 10b. County  MD Washi	ngton 10c. Cit	y, Town or Lo	sboro	_			10d. Inside City Limits 1 ☐ Yes 2 ★No
9003	within 72 hours after death with the Maryland ane. then "naturel", or items 23e or 28e-f show in Mudical Everifier must be notified at	Completed by Funeral Dire	10e. Street and Number  6033 Clevelandtow  11. Marital Status  1☑ Never Married 2☐ Married  3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		10f. Zip Code  2171  Was Decedent of His If Yes, specify Cuban  1 ☐ Yes 2 ☐ No	panic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	1	erican Indian, le, etc. Vhite
121215-0036	filed within 72 I Hygiene. tther then "nat ant, I're Midic		15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) N/A	ring most of worl	king 10	N/A	/Industry
Maryland	2 should be fi and Mental F is marked ot eumatic ever	To Be	17. Father's Name (First, Middle, Last)  Kevin Jones  19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Maili	ng Address (Street ar	Lorrai	ne Baughe	er	Zip Code)
Baltimore, N	ss 1 and of Health item 27		M/M Kevin Jones/pa  20a. Method of Disposition  1 Surial 2 Cremation 3 F  1 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, cre-	33 Clevelar position (Name of matory or other place to Valley C	10/0	Date 20 5/2006	nsboro, MD Oc. Location - City or Pleasant	7
Balt	permit. Page Department of Importent: If any njury or angs.		21. Signature of Funeral Service Licents  23a. Pay 1. Enter the disease, complete synck, or heart failure. List only or		4	Plane and Fidnes 12 Washing ter the mode of dying	rton Road	e and Cha d Westmi	pel, P.A. nster, MD	21157 Approximate Interval Between
	Physician /Medical Examiner		Imma ate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	14 1	8				3 weeks
8760,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq						
.O. Box 68	The law requires that the death certifica tile has been signed by the attending phoage 2 should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Records, P.	w requires that been signed b should be delt	Pa	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	inderlying cause giver	n in Part I.	23e. Did toba		o the cause of death?
Vital Rec		e Complet	25. Was case referred to medical				OC Place of Dag	24a. Was an autopsy performed 1 Yes 2 Sth. (Check only one	prior to death?	utopsy findings available completion of cause of s 212(No
of	ding Phys h. After this funeral di	To B	examiner?  1 Yes 2 Yo F  27. Manner of Death  1 Vatural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	° 4 ☐ Nursing H		ce 6 ☐Other (Spe	ocity)
Division	Dir	al Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At h building, etc. (Specil sician: To the best of my kno	y) owledge, deal	h occurred at the time	a, date and place	City or Town,	use(s) and manner as	s stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and/or in	29c. License	nion, death occur number	rred at the time, dat	e and place, and due d. Date signed (Mont	e to the cause(s)
	wrt	ate	30. Name and address of an who con Part I C I C I T T T T T T T T T T T T T T T	mpleted cause of death (Iter	Thor	Print)	nson	Dr Stell	Of Free	Clerick, MI

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 0140 09 2006 Ferdinand Kuyatt 29 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ₩ M 2 🗆 F 507-30-9737 Director Nov. 22, 1931 NE Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits orant: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other treumatic event, the Medical Examinal must be notified at 1 Yes 2 No Director Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14448 Bakersfield Court 20906 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1955-57 1 XNever Married 2 Married Pages 1 and 2 should be filed within 72 hours aftenent of Heelth and Mental Hygiene. Int: if item 27 is marked other then "natural", or i Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Official Court Reporter State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christian A. Kuyatt Rosalie Repp 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 East Elizabeth Ave., Kingsville, TX 78363 Bruce Neal Kuyatt / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or once. Metropolitan Crem. Sept.30,2006 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W Silver Spring, MD 20901 Kuland I Dolas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent Physician /Medical Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence off or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate hes 1 ☐ Yes 2 100 Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After t Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending Injury 1 Yes 2 No death. 2 Accident investigation ₽ Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 14 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09/29/2006 D0061681 12+ re and address of person who completed cause of death (Item 23a) (Type, Print) 10/81 KILL rince the lip 10 gistiar's Signature 31. Date filed (Mon.

DHMH 17 Rev 1/2001

Registrar

Coasti

			For State	State of Maryland		ent of Health			711116	32919
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Kodjak			2	Reg. Date of Death Month	Day Year / 2006	3. Time of Death P
	Examir Funeral Director	ier	090-34-5907	e medical Cer	rker		bury	Date of Birth (Month, Day, Ye		lace (State or Foreign
id 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23a or 28a-1 show aumatic event, the Madical Extending must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  VA 10c. Com  10e. Street and Number  5353 Main (  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu  (Specify only highest grad  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:	6. 13. Was D If Yes, 1 □ Ye  16a. Decedent's (Give kind c	ecedent of Hispanic specify Cuban, Mexicos 202 No Specify Cuban of work done during in Truse retired)  18. Mexicos 202 No Specific Society Cuban of Work done during in Truse retired)	nost of working	y Yes or No- can, etc.)	Citizen of What Cour  U. SA.  14. Race - Americ Black, White,  Specify: W.A.  D. Kind of Business/Inc	0d. Inside City Limits 1 M Yes 2 □ No http? can Indian, etc.
Baltimore, Maryland	permit. Pages 1 and 2 should be Deperment of Heelih and Mental Important: if Item 27 ie marked o any injury or other traumatic eve QDGs.	ToB	19a. Informant's Name/Relationship (T)  20a. Method of Disposition  1 \( \text{Surial} \) 2 \( \text{Cremation} \) 3 \( \text{F} \)  4 \( \text{Donation} \) 5 \( \text{Other} \) (Specify)  21. Signature of Funeral Service Licens	emoval from State	5353 ace of Disposition metery, crematory Chanics	ress (Street and Nut	treet Date 1013	China e 200 OL C	Katy K ty or Town, Istate, Zip Location City or To hincotea neotea green	FL 23336 wm, State VA 2336
760,	be executed by executed by sician and burial-transit but the burial-transit but the burial-transit but the burial-transit but the burial-transit but the burial-transit but the burial-transit but the burial-transit but the	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death, the cause on each line.  A SPICA A  Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the cause of the consequence	ence of):	mode of dying, such	as cardiac or r			Approximate Interval Between Onset and Death
s, P.O. Box 68	The law requires that the death certificate be executed tee has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal   4 Pregnant at time of de 9 Unknown	death 3 ⊟Ectop ath 5 ☐ Othe	ic pregnancy r (specify) ng cause given in Pa	art I.	23e. Did tobac	23d. Date of delive Month	Day Year
ital Records,	hysician: The law require his certificete has been sig il director, page 2 should b	e Completed by	25. Was case referred to medical	<b>S S</b>		26. PI	lace of Death (C	1 Yes  24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available inpletion of cause of
Division of Vital	Attending Physician: or death. ector: After this certifice by the funeral director.	Certification: To B	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28¢	d. Describe how i	e 6 □Other (Specifingury occurred	
2	To the Hospitel or Attending Physically Annus attended in Tothe Funeral Director: Affer this completely filled in by the funeral directors.	Medical Certi	4 Homicide determined  29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	28e. Place of Injury - At hor building, etc. (Specify) sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death occu	rred at the time, date	and place, and	City or Town, S	(ate) e(s) and manner as si	ated.
,	To th within a comp	Me	29b. Signature and title of certifier  30. Name and address of person who co	mpleted cause of death (Item	V M7 23a) (Type, Print)	29c. License numb			Date signed (Month, 10-02-250	
	Sta Registr		Anthony Adrignolo 31. Date fleed (Month, Day, Year)  OCT 0 3 2	32. Rogistrar's Signate	ne Bluff		AUSbery	/ MD		

		For State	State of Maryland	d / Depa	artment of H	ealth an			06	32920
		Registrar  1. Decedent's Name (First, Middle, Last)		Cel	lineale of L	Jeani	2. Date of De	Reg. No.		3. Time of Death
Physicia	an		2011				Month	Day	Year	14210 M
/Medic	al	Edith Dorothea KA			# 03 T	1 4 D	10_		2006	1 1-10 "
Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or		eath	4c. County		
7		Washington County			Hagerst If Under 1 Year	OWN If Under 24	Hre I a a		ington	
Funeral		5. Social Security Number 6. Sex	7. Age ( <i>In yr</i> s. <i>I</i> .	ast σιππααγ) Yrs.	Months Days		vin. (Month, Da	y, Year)		ace (State or Foreign
Director		139-18-6562 Usual Residence of Decedent	67	113.			Sept.	17 1919	New	Jersey
and		10a. State 10b. County	10c. City	, Town or Lo	ocation				10	d. Inside City Limits
burs after death with the Marylan rail; or Iteme 23a or 28e-1 show	ច	M 1 1 1 1		77						1 X Yes 2 □ No
the A	Director	Maryland Washingto  10e. Street and Number	n	наде	rstown 10f. Zip Code			10g. Citizen of V	Mhat Count	n/2
with					Tot. Zip Code			rog. Onizer or	Wilat Count	y:
e 23	Funeral	1734 Edgewood Hill	.s Circle 2. Was Decedent Ever in U.:	C 12	217	10	? (Specify Yes or No	USA	ce - America	a Indian
er de	Ľ,	The state of the s	Armed Forces?  1 ☐ Yes 2 📉 No	5. 13.	If Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)		ck, White, el	
s aft	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specif		
72 hours after dea "netural", or Iteme		15. Decedent's Educ		163 Dece	dent's Usual Occupa	ation		16b. Kind of B	White	
n 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of	working	TOD. KING OF D	daniesa/indo	istry
withi Bne.	Ĕ	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		Homemaker	,		Her ow	m hom	0
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. A dether then "netural; or items 23s or 28s-f show do other then "netural; or items 2ss or 28s-f show event, the Madical Expanirer mast be notified at	e C	17. Father's Name (First, Middle, Last)	U		Homemaker		Name (First, Middle,			
d be do	00	Theodore Applegate					_		,	
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental Barrene.	2	19a. Informant's Name/Relationship (Typ		10h Mailie	an Address (Street	Ma	ry unkr		State Tie (	Pada)
12 st h and 7 ts r traur			•		862 51					
1 and 1 and Health em 27 ther tr	-	Susan Karsay Thomp	son -Daughter	lace of Dieno	46 Sunris	e Driv	e, Hagerst	20c. Location	City or Toy	40
Dermit. Pages 1 and 2 should Department of Health and Men Importent: If ten 27 is marke any injury or other traumatic. 2006.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	C.	emetery, crei	natory or other plac	θ)	Date	20c. Location -	- City or Tow	n, State
Pag ment: ent:		4 ☐ Donation 5 ☐ Other (Specify)	Res	st Hav	en Cemete	ry 10	/7/06	Hagerst	own,	Maryland
permit Depart Import		21. Signature of Funeral Service License		22	2. Name and Addres	s of Facility	Minnich	Funeral	. Home	
1 80 5 9 9		1 man Liverson	1	4	15 E. Wil	son bl	vd. Hager	stown,	Md. 2	1740
Physician /Medical Examiner per policy (p. 1976). The prival-transit property of the prival-transit property of the prival-transit property of the prival proper	l Examiner	shock, or heart failure. List only one temmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	vence of):	Coronary	ntai Art	rction ény dise	rase		Interval Between Onset and Death Onset and Dea
ate be e. hysicien the buria	dicai	d.							-	
ne death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Do 9 ☐ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				nte of delivery	y Day Year
res that the signed by be detac		Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to the	cause of death?
uires Isign	d by	Advanced	Deme	uti	a.		10	Yes 2 No	3 Proba	bly 4 Unknown
w requir been si should	Completed	7. 1.5.	6184.056 621	. 0 144	1 11		24a. Was	24h	Mara auton	ou findings available
hes pe 2	m d	- Avon dell	wey av	ie vvo			— autor	osy ormed?	prior to com death?	sy findings available pletion of cause of
icete	ပိ						1 ☐ Yes		1 ☐ Yes 2	! 🗆 No
iciar sertif ector	Be	25. Was case referred medical examiner?	ospital:		Oth		Death (Check only of	one)		
this aldir	မ	1 195 2 140	1 ≥ npatient 2 ⊔	ER/Outpatier		4 🗀 Nul Sil	ng Home 5 Resi			
ing ing	ő	27. Mann of Death 1 D atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl		28d. Describe	how injury occur	rea	
tend leath for: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no ce				Yes 2 □ No				
after d after d i Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	ber or Rurai	Route Number,
To the Hospitel or Attending Physician: The law within 24 hours after death, within 24 hours after death, To the Funerel Director: Attenthis certificate hes completely filled in by the funeral director, page 2.	ledical C		cian: To the best of my kno- er: On the basis of examinat and manner stated.							
o the ithin i o the	Med	29b. Signature and title of certifier	And mariner states.	72	29c. License	e number	T	29d. Date signe	ed (Month, D	ay, Year)
F \$ F 8		PO TK. II	MII Ham	14	110	n	10011200	K	24	5 MARI
		noven John	1 "N 1C1300	104 11	YS/CHILL	W (	207539		C	1,400
54-10		30. Name and address of person who con	npleted cause of death (Item	23a) (Tybe	DUA/ S	7 41	1 CATO	WHA/ K	in i	117/19
) H-10		31. Date filed (Month-Day, Year)	32. Registrar's Signa	1 VIV	1460	i. LUN	12/300	014, ((	00	+1171
Sta	ite ar	MCT 17 5 20	AA SE. Hagistiai sigila	La A	1 1.					

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records. P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Minnie MILLSTEIN Month Year **Physician** 8:50 P M September 29, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1801 E. Jefferson St., #403 Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 109-01-3601 90 New York Director July 9, 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Montgomery Maryland Rockville 1 ☐ Yes 🎾 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 E. Jefferson St., #403 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after Armed Forces? 1 □ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. Int: if item 27 is marked other then Efementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Manufacturing 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Zahn Dina Faust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Millstein, Son 11212 Blackhorse Court, Potomac, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of the 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 10/03/06 Riverside Cemetery Saddlebrook, NJ 21. Signature of Funeral Se vice Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the 1 ☐ Yes 2 🔀 No à 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>م</u> 99 Alzheimer's Disease 2 (X) No 3 Probably 4 □Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 Tyes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how intury occurred Certification: Division or Attending To the Funerel Director: Affe completely filled in by the Completely filled in by the Completely filled in by the Completely filled in by the Completely filled in by the Complete of the Comp 1 X Naturaf 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Torrithing Physician: To the best of my knowledge, neight occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cenden October 2, 2006 D 0036716 maleco 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10

DHMH 17 Rev 1/2001

State

Registrar

Andrew Kundrat, M.D., 6121 Montrose Road, Rockville, MD 32. Segistrar's Signature

3 2006

State of Maryland / Department of Health and Mental Hygien 32923 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ° Physician 8:55<sup>A</sup> M Rebecca Miller Sept. 29,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Friends Nursing Home Sandy Spring, Md. Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) Months Hours Min. 1 ☐ M 2 € F 95 Penná. **Director** 182-26-5708 Dec.9,1910 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumetic evant, the Medical Examt. Includits to notified at once. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. Montgomery 1741 Norwood Road, Sandy Spring 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1741 Norwood Road 20860 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = **2X** Xo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1XXever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XXIo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life... DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Miller Elizabeth N/A Miller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Lopsuncoski/Niece 4325 Leeds Hall Drive, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Magdaline Crematory 10/3/06 Ringtown, PA ` 4 ☐ Donation 5 ☐ Other (Specify) Blv.Spring,MD 21. Signature of uneral Service Licer Columbia 22. Name and Address of Facility 9241Philip D. Rinaldi Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician NERWOHIT disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner YRS anding physician and use as the burial-transit The law requires that the death certificate be executed EM YPE P resulting in death) Last Due to (or as a consequence of Box 68760. Physician/Medical EMELLIN IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by ARTERY 1 Yes 2 No 3 Probably 4 Unknown 05094 BUN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an THUB page 2 autopsy performed? Yes 2X No certificate 1 ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: i Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 52392 ddress of person who completed cause of death (Item 23a) (Type, Print) CHANGY Rd. SILVER SPRING Md BR1665 GLANC E-1731 JOHN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 2006 0

Registrar

State of Maryland / Department of Health and Mental Hygienes 32924 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** '28**,** Melendez September 2006 5:40 Nelson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. 2006 Director None Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other then "natural; or items 23a or 28e-f ehow ury or other traumatic event, the Medical Examinar must be mailfied at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12123 Blu Hill Road 20902 United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 El Salvador 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nelson Melendez Sr. Marciela Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Melendez / Father 12123 Blu Hill Road; Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department c important: If any injury or Gate of Heaven Cemtery 10/3/2006 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Simple and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike; Rockville, Maryland 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of comshock, or peart failure. List only Immediate Cause (Final disease or condition resulting in death) plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Onset and Death **Physician** Intraventricular Hemorrhage 2 days /Medical Due to (or as a consequence of): Examiner Hypovolemic Shock 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Placental Abruption 3 days the ettending physicien and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Extreme Immaturity 3 days LE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No hes page 2 autopsy performed this certificate 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 🖾 No 1 Alnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier To the ! 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D050522 9/28/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, Maryland 20910 M.D. Matthew B. Picard, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 03 Registrar

			1 - For State Registrar	State of M	<i>l</i> larylan			it of Hea e of De		d Mental I		ne No.20(	06	329	125
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)						2. Date o		Day	Year	3. Time of E	Death
	Physici /Medio		Rafaela Martir	nez						Sept	embe	r 27,	2006	8:05	$p^{M}$
7	Examir	ıer	4a. Facility Name (If not institution, give		r)			Town, or Loc		eath		4c. County of Death			
			Suburban Hospita  5. Social Security Number 6.5		h = = //=	last birthday)		ethesda	i Under 24 H	drs la Dava	( Diah	Mont	gomen	J	· · · · · · · · ·
ш	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	1  M 2		10 Yrs.	Months				Day, Ye	1925	Count	ace (State or ry) Salvado	
			Usual Residence of Decedent							oct.	<del></del>	1925	111	iaivau	01
-	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City	
1	Ba-f.	cto	Maryland Montgo	mery	Ro	ckvill	.e							1 🖾 Y <i>e</i> s ∶	2 🗆 No
	MIT II	Director	10e. Street and Number				10f. Zi				10g	Citizen of W			
	23a	ra l	1631 E. Jeffers	on Street		C 12.1		20852	nio Origin?	/Specify Voc	, No	Unite	d Sta		
	in the case of the	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Force	s?	.5.	f Yes, spe			? (Specify Yes o uerto Rican, etc.			, White, e		
99	urs ar	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ⊠ Y <i>e</i> s	2□ No S	Decity: E1	Salvad	or	Specify:	Whit	:e	
0	be lied within 72 nouts after death with the Maryland ital Hygiene. Ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr.			16a. Dece	dent's Usu	al Occupation			16	o. Kind of Bus	sinøss/Inde	ıstry	
21	<b>C</b>	npie	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT L	se retired)	g 031 01	Working					
2	ygier t	ပိ	0			Hom	emak		Mash ada 1	Name (First, Mi		Own Ho			
Maryland 21215-0036	od of T	Be	17. Father's Name (First, Middle, Last					18.					*)		
<u> </u>	d Me Tark	ဥ	Mercedes Martin  19a. Informant's Name/Relationship			19b. Mailir	na Addres	S (Street and		r Rural Route Ni		andez itv or Town, S	State Zio i	Code)	
<u>8</u>	Ith ar 27 is 27 is		Gloria E. Martin		hter		-			reet; R					0852
ā.	f Hea f Hea item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of		Date		c. Location - (			
Ê,	Page Tition of o	1	1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Speci		10	Souls			10	/03/200	6	German	town.	Marv.	land
Baltimore,	permit. Pages 1 and 2 should be lited wit Department of Health and Mental Hygient. Important: if Item 27 is marked other this any injury or other traumatic event, the once.		21. Signature of Funeral Service Lice	nsee	1					neral a					
m ;	898 29		M3. 4			10	40 R	ckvill	e Pi	ke; Roc	kvil	le, Ma	rylar	id 208	852
			23a. Part1. Inter the disease, or con shock, or heart failure. List only	plications that caus one cause on each	ed the deat line.	h. Do not ent	er the mo	de of dying, su	ich as care	diac or respirato	ry arrest			Approximate Interval Betw Onset and Di	een
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Hemopt	ysis									Diise and Di	Datii
	/Medical Examiner		resulting in dealth)	Due to (or a	as a conseq	uence of):									
		je l	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	as a conseq	uence of):									-
1	ured ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	exec en an rial-tr	Exa	resulting in death) Last	Due to (or a	as a conseq	uence of):									
8760	death certificate be executed electroning physicien and for use as the burial-transit	dlcal		_ d											
9 ×	ling pl	Med	IF FEMALE:	00- 11											
Вох	ettend for us	ician Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Feta	ıldeath 3□	Ectopic p					23d. Date Mon	of deliver	•	ear
o ]	by the etached	Physic	1 □ Yes 2 ☎ No 9 □ Unknown	9☐ Unknown		eath 5L	J Other (S	эөспу)							
o.	Ine law requires that the ste has been signed by the ge 2 should be detached.		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	cause given in	Part I.	23e. I	Did tobac	co use contri	bute to the	cause of de	ath?
Vital Records,	quires an sign uld be	ad by								_	I ☐ Yes	2 🖾 No	3 🗍 Proba	ıbly 4 ∐Ur	nknown
ပ္က	aw requires to see the second of the second	ompleted									Mas an	24b. W	ere autop	sy findings a	vailable
¥ }	the lay	E									utopsy performe es 2 🗵	<b>1</b> ? <b>de</b>	eath?	ipletion of cai 2□ No	use or
Ita	ysician: The is certificate his director, p. 96	BeC	25. Was case referred to medical examiner?					26	Place of I	Death (Check o					
	rnysic this ce rai dire	၉	1 ☐ Yes 2 ☒ No			ER/Outpatier			I ☐ Nursin	ig Home 5 □ 1				1	
ב	Alter I	on:	27. Manner of Death 1 △ Natural 5 □ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury		28c. Injury at Work?	o $\square$ No	28d. Desci	ibe how	injury occurre	rd		
Division of	T = 10 10 1	cat	2 Accident investigation 3 Suicide 6 Could not be	OB Place of	Injuny - At h	ome farm str	M factor		2 🗆 No	28f Locati	on (Stree	t and Numbe	r or Rural	Route Numb	ner
	i diff	Certification;	4 ☐ Homicide determined	building,	etc. (Specil	(y)	001, 140101	y, omos			Town, S		, 0, 1,0,2,	710010 1101110	Or,
	o the Hospital or vithin 24 hours after o the Funaral Dir ompletely filled in	alc		hysician: To the be											
j	I o the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Exa	miner: On the basis and manner		ition and/or in	vestigation	n, in my opinio	n, death o	ccurred at the ti	me, date	and place, a	nd due to	the cause(s)	
	within 2 To the	Σ	29b. Signature and title of certifier	1			29	c. License nu	mber		29 <b>d</b> .	Date signed	(Month, E	ey, Year)	
,	00		1 Visualjan	1 Ly	Sia	au		Dog	121	/		1/28/	06		
	A Cal		30. Name and address of person who IZO [ Service 31. Date filed (Month Day Year) 3	completed cause o	f death (Iter	п 23а) (Туре,	Print)	- bins	0,	110					
	Sta	te.	31. Date filed (Month Day, Year)	32. R6i	strar's Signa	ature	100	-	u 1	My					
2	Regist		UCT 0 3	ZUUB 65	BINCO.	K B	DEALL								

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Cell	rtificate of Death	Reg.	No. 2006	32921
Physicia		Decedent's Name (First, Middle,Last)		Date of Death     Month     Date	av Year	Time of Death 1355 hrs
ledical Exami	ner	JENNIFER JOY ABERBACH MARCUS	La Cil Tanana La Cil	October 4, 2		1355 1115
and the same		4a. Facility Name (if not institution, give street and number) 705 S. Cherry Grove Ave Apt 103	4b. City, Town, or Location of Do	eatn	4c. County of Death Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		4Hrs 8 Date of Birth/N	MM/DD/YYYY) 9. Birthp	lace (State or
Funeral Director		139-80-7871 1_M 2KF 36	Months Days Hours	JUNE 11,	Foreign 1	NEW YORK
any	ł	Usual Residence of Decedent         10b. County         10c. City	Town or Location		10	Od, Inside City Limits
* .		MARYLAND ANNE ARUNDEL	ANNAPOLIS		1	Yes 2 X No
aryland 8a-f show at once.	윉	10e, Street and Number	10f. Zip Code	10g.	Citizen of What Country	n
th the Maryland 23a or 28a-f sho notified at once	Director	705 S. CHERRY GROVE AVE APT 10	3 21401		U.S.A.	
with t	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U	S. 13. Was Decedent of Hispanic Origin?		14 Race - American	n Indian, Black,
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.  Specify: [A	HITE
ours a	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind		6b. Kind of Business/Ind	ustry
72 hc	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use			
vithin ene.	Ē	4	WEBSITE DESIGNER			TECHNOLOGY
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Ŝ	17. Father's Name (First, Middle, Last)		lame (First, Middle, Maid	den Surname)	
21215-0036 Juld be filed within 72 Mental Hygiene, marked other than '	Be C	PAUL ABERBACH  19a. Informant's Name/Relationship (Type, Print )	CAMILLE 19b. Mailing Address (Street and Number	E ENNEVER	City of Town State 7	o Codo)
MD 2 nd 2 shoul alth and N m 27 is n	٩	PAUL ABERBACH FATHER	205 E 22nd STREET #4			10010
ire, MD 21215-003 s. I and 2 should be filed with of Health and Mental Hygiene. If item 27 is marked other it ner traumatic event, the Med	ŀ	20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery,		Oc. Location - City or To	
<u> </u>		A Danial 2 Oremation 5 21 Removal from state	crematory or other place)	\ /00 /2006 B	ADAMIC MES	IEDCEV
U min min min min min min min min min min		4 Donation 5 Other Specify: CED 21 Signature of Fungeral Service Licensee			ARAMUS, NEW	
Baltimo permit. Page Department o Important:		(CARATAT)	22. Name and Address of Facility 11 ANZANSKY — GOLDBER 1170 ROCKVILLE PI	RG MEMORIAL	CHAPELS, I	INC. IND 20852
Physician		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	shock, or heart	Approximate Interval
/Medical		Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Narcotic Intoxic  Due to (or as a consequence of	ation associated with acut	- 1		
		Sequentially list conditions, b				
	<u>اةِ</u>	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	or).			
=	Examiner	(Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of the cons	of):			
760, cate be executed physician and the burial - transi	I	d				
760, cate be execute physician and he burial - tran	Medical		a,27,28a-f,PII,perME,g860,	10/20/06 TT		
3760, ficate be g physic s the burn	N.	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the 1 Live birth	П		23d Date of delivery  Month Day	Year
Box 68: death certifi the attending of for use as I	sician/	past 12 months?		egnancy	Month Day	real
Bo e death the att	Physi	1 Yes 2 No 9 V Unknown 9 Unknown	24P 34B 7 = 2 200 200 200 200 200 200 200 200 200	~		
P.O. Box 68 es that the death certifiganed by the attending or detached for use as		Part II. Other significant conditions contributing to death but not r			cco use contribute to the	
s, P.( ires that signed d be det	d by	Atherosclerotic cardiovascular dis	sease	1 Yes :	2 No 3 Probab	ly 4 🗸 Unknown
Division of Vital Records, Isla or Attending Physician: The law requires its after death al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed			24a. Was an autopsy		sy findings available inpletion of cause of
Recc The lav icate ha	m o	_		performe	death?	2 No
tal Rection: The certificate ector, page	O	25. Was case referred to medical	26.Place of Death (Ch	eck only one)		
Vital   hysician: this certifi I director,	.0 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other No	ursing Home 5 Res	sidence 6 🗸 Other: S	cene
n of ling Ph After t funeral	ı.	27. Manner of Death 28a Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d Describe how	injury occurred	
ion ttendi leath tor:	aţi	Natural 5 Pending Fnd 10/4/2006	Fnd 1:30 pm 1 Yes 2 X No	unknown		
ivisior for Attencafter death Director:	iệi l	3 Suicide 6 X Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office building, etc.		et and Number or Rural	
Spital neral filled	Certification:	4 Homicide determined (Specify) House		Apt 103 Ba	itimore; Mberi	y drove rive.
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificate the Lours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination and manner stated				
F 2 F 0	ž	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month	, Day, Year)
		highi, mid	O.C.M.E.		October 5, 2006	
		30. Name and address of person who completed cause of death (Item				
	D W	•	Penn Street, Baltimore, MD 21201			
Si	tate	31. Date filed (Month, Day, Year) 2006 32 Registrar's Signat	7. Combi			
Regis						

			1 - For State Registrar	State of Man		artment of F			ene g. No. 2 0 0 6	32927	
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las. Suzanne L. McCrea	_				2. Date of Death Month	Day Year	3. Time of Death	
,	Examin	_	4a. Facility Name (If not institution, give Peninsula Regio.	street and number) Nedica	1 Center	4b. City, Town, o	Location of Deal		4c. County of De	rico	
	Funeral Director		5. Social Security Number 219-56-7967  Usual Residence of Decedent	JM alXIE	n yrs. last birthday, 54 Yrs.	Months Days	Hours Min.		Year)	irthplace (State or Foreign Country) ISbury, MD	
	ith the Maryland or 28a-f ehow	Director	10a. State         10b. County           MD         Wicomic           10e. Street and Number		Oc. City, Town or L Salisbur			10	10d. Inside City Limits  10g. Citizen of What Country?		
020	n 72 hours after death with the Maryland "natural", or flems 23a or 28a-f ehow sulcal Examinational by collined at	by Funeral	920 E. Church St.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S. 13.	Specify Yes or No- to Rican, etc.)	USA  No-  14. Race - American Indian, Black, White, etc.  Specify: White				
21212-0030	t within iene. r than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup e kind of work done DO NOT use retired isabled	pation during most of wo d)	rking	6b. Kind of Busines ${ m N/A}$	s/Industry	
Maryland 2	be d la	To Be C	17. Father's Name (First, Middle, Last) Leroy Lutz  19a. Informant's Name/Relationship (T	vna Print'i	10h M-10	na Addrass (Chro	Joan Bra		laiden Surname)  City or Town, State,	Zin Code)	
baltimore, mai	is 1 and 2 soft Heelth ar item 27 is other trau		Rue McCready - Hu  20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3 \( \) I  4 \( \) Donation 5 \( \) Other (Specify,	sband	920 E	Church  osition (Name of matory or other place	St., Sal	Lisbury, N		or Town, State	
Dall	permit. Pege Depertment of Importent: If any injury or once.		21. Signature of Euneral Service License	y Black				ounds Func , Salisbu	eral Home ury, MD 2	1804	
	Physician /Medical Examiner	er	23a. Part. Enter the disease, or comp shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a c	splicem	16.	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death	
8/60,	certificate be executed ding physicien and ise as the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Liver care hosis  Due to (or as a consequence o):  Hero in this c						Years Years	
O. BOX O	death e atter	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	<b>y</b>		23d. Date of d Month	elivery Day Year	
ords, P	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significant conditions co	ntributing to death but n	not resulting in the c	ınderiying cause gıv	ren in Part I.			to the cause of death? Probably 4 dunknown	
Vital Records,	The ate h	e Completed	End stage Diabetes 25. Was case referred to medical	nellitus	ilvæ.				No 1 ☐ Ye		
DIVISION OF VI	ding Phys h. After this funeral di	ertification: To Be	evaminer?	dospital: 1 Inpatient 28a. Date of Injury (Month, Day Y.	2 ER/Outpatie	of 28c. Injui	ner: 4 ☐ Nursing I	ath (Check only one dome 5 Resider 28d. Describe how	nce 6 Other (Sp	recify)	
	e Hospitel or Atten 24 hours atter deat E Funerel Director: etely filled in by the	O	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	Specify)			City or Town,	State)	Rural Route Number,	
	\$ = \$ B	Medical	29a. Certifier 1	sician: To the best of niner: On the basis of ex and manner stated	camination and/or in	th occurred at the til nvestigation, in my o	opinion, death occ	urred at the time, da	use(s) and manner at the and place, and du	ue to the cause(s)	
)	on V with		5 - A Roga  30. Name and address of person who c	Jolly  ompleted cause of deal	h (Itam 23a) (Tvna	Do	06071	5	october,	1,2006.	
1	Sta	te	31. Date filed (Month, Day, Year)	moll St	Signature	m , pu	316 O	301 (2	eyed le	za Jahah My	
	Registr	ar	OCT 0 3 2	006	. K 1	backer					

State of Maryland / Department of Health and Mental Hygiene 2006 32928 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Miriam E. Marinelli September '25, 2006 1:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 1 1 F Months Days Hours Yrs. Director 24,1920 Washington, DC 579-03-8535 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Examiliar must be notified at 1 ☐ Yes 2 No Anne Arundel Edgewater Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21037 3268 Rolling Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 feem 27 ie marked other then "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Caldwell Ida Padgett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Willard Drive, Edgewater, MD 21037 Jimma M. Hans/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 5 ☐ Other (Specify) Kalas Crematory 9-26-06 Edgewater, MD 4 ☐ Donation 21. Signa re of Suneral Service Lic 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ur as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the a should be detached Part II. Other, significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 Tes 2 70No To the Hospital or Aurename, within 24 hours after death.

To the Funeral Director: After this certific: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tes 2000 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) House 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Ave. Aditya Chopra, M.D. #231, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State SEP 2 7 2006 Registrar

			For	State	of Maryla						-	_		0.00	
			1 - State Registrer			Ce	rtificat	e of D	Death				. 006		
Phy	sicia	n	Decedent's Name (First, Middle,								2. Date of De Month	Day			
/M	edic	al	William  4a. Facility Name (If not institution, i	R.	Mila	ni	4b Ciby	Town or	Location o		Octobe:	-	200 County of De	1	) P "
Exa	mine	er	8308 Glen Heat					eder		// Death		10.	Frede		
Fune	ral			. Sex	7. Age (In yrs	s. last birthday			If Under:	24 Hrs. Min.	8. Date of Bir	th Vear	9. B	irthplace (State Country)	or Foreign
Direc			347-84-3221	1⊠M 2□F	17	Yrs.	MOUTUS	Days	Hours	[A1161"	(Month, Da Sept. 2	24, 1	.989 Pé	ennsylva	nia
and		1	Usual Residence of Decedent  10a. State 10b. County		10c. 0	City, Town or L	ocation							10d. Inside C	City Limits
Mary -feho		ţō	Maryland Frede	rick		Fre	deric	k						1 🗆 Yes	2 <b>X</b> No
h the		Funeral Director	10e. Street and Number				10f. Zip					10g. Citiz	zen of What	Country?	
23e c		a D	8308 Glen Heath	er Driv	e			2170	2					States	
er dea		nuel	11. Marital Status	Armed	ecedent Ever in Forces?	U.S. 13.	Was Deced	dent of His orly Cubar	spanic Orig n, Mexican	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, WI	nerican Indian, nite, etc.	
rs aft		by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, € Year or	s 2⊠No Give Dates:		1 ☐ Yes	2 <b>⊠</b> No	Specify:				Specify:	White	
2 hou			15. Decedent's	Education		16a. Dece	dent's Usua	al Occupa	ition			16b. Kir	nd of Busines	s/Industry	
thin 7		Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	b kind of wo DO NOT u	se retired)	uring mosi	t or workir	ng				
led w lygien her th	1		0				None		10 Matha	da Nama	/Fina biiddle	Maida	Not	ne	
i be fi		Be	17. Father's Name (First, Middle, La William G. Mila								(First, Middle		Sumame)		
should Me mark		ပ္	19a. Informant's Name/Relationship			19b. Mail	ing Address	(Street a			I Route Numb		Town, State	Zip Code)	
atth a			William G. Mila	ni / Fa	ther	8308	Glen	Heat	her D	rive	Free	derio	k, Mai	cyland 2	1702
of He of He		Ì	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3		20b.	Place of Disp cemetery, cre	osition (Nar	ne of			ate			or Town, State	
Pag ment tant:			4 □Donation 5 □ Other (Spe	cify)		. John			у	7, 20	006			Maryla	
peritinities of the proof of the period of the period of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural", or terms 23e or 28a-f show than the period of the permit of t	once	ŀ	21. Signature of Funeral Service Li	censee		1	2. Name an	d Addres	s of Facilit	y Sta	uffer I	Funer	al Hon	nes, P.A ryland	21702
ore As			23a. Part1. Enter the disease, or co	omplications tha	t caused the de								ck, ria	Approxima	
Physici	20		shock, or heart failure. List or Immediate Cause (Final	nly one cause or	n each line.	.1		, ,	N		+			Interval Be Onset and	tween
/Medi	cal		disease or condition resulting in death)	a. CO	to (or as a cons		~ com	+	H	((2)					
Examir	-		Sequentially list conditions.	b. R	=5 DIF	dory	F	2,1	Ure					220	aju
De si	i i	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or asla conse	equence of):								220	1
xecut and	8	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conse	equence of):	71.15	ase						1.39	ears
ate be executed hysician and		cai		d											
rificat ng Phy	2		IF FEMALE.												
ath ce	200	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1□Live	outcome of preg e birth 2  Fe	tal death 3	□Ectopic pr					2	23d. Date of o	- /	Year
the a	2	Physician/Med	1 Yes 2 No	4 □ Pre 9 □ Uni	gnant at time of known	death 5	Other (sp	ecify)						Duy	
res that the death certification by the attending principle of the attendin	800		Part II. Other significant condition	s contributing to	death but not re	esulting in the	underlying c	ause give	n in Part I.		23e. Did t	obacco u	se contribute	to the cause of	death?
requires been sign	2	ed by									10	Yes 2	ZNo 3□	Probably 4 🗆	Unknown
le law requir	4	plet									24a. Was		24b. Were	autopsy findings completion of	available
The The	200	Completed									perfo	rmed?	death	?	02030 01
vician: The certificate	600	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o				
Phys C	8	ဥ	1 ☐ Yes 2 ☑ No  27, Manner of Death	11		☐ ER/Outpatie			4 140		ne 5 Resi			oecify)	
Ith.: Afte		it or	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		te of Injury onth, Day Year)	Injury	м	8c. Injury Work 1 🗆 Y	? ′es 2 🗆 I				,		
r Atte	5	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Pia	ce of Injury - At	home, farm, s	reet, factory	, office		2	28f. Location (	Street and	Number or	Rural Route Nur	nber,
oltal ol rel Di	2														
Hosp 24 ho	areny .	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Exone)	Physicien: To to ceminer: On the and ma	the best of my k basis of exami anner stated.	nowledge, dea nation and/or i	th occurred ovestigation	at the tim, , in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(	s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Interdor: After this certificate has been signed by the attending physician and more considered to the property of the physician and the death of the certificate has been signed by the attending physician and the death of the certification and the physician and the certificate that the death of the certification and the	dia	Me	29b. Signature and title of certifier		J. Siarou.		290	. License	number			29d. Date	e signed (Mo	nth, Day, Year)	
) ہے ۔۔			1	00	ler 1	7		D 3	353	r		1		2. 20	006
2			30. Name and address of person w	no completed ca	se of death (M	em 23a) (Type	, Print)			A;		•	f -	1	
U.	0.		31 Date filed (Month Day Vear)	Plee	egistrar's Sig	147	7 5	Ave	4	Hu	FV.	وطف	ick,	W9 5	1701
Red	Stat gistra		31. Date filed (Month, Day, Year) OCT 0 4	2006	Charles 319	15 19	porte		7						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Terry Lee Montague	1- For State		nt of Health and Mental H	0	006 0000
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)			Reg. No  2. Date of Death	3. Time of Death 3
Medical Examiner	Terry Lee	Montague		Month Day Yea October 1, 2006	1133 hrs
(")	4a. Facility Name (if not institution, give 23415 South Patuxent Beach	street and number)	4b. City, Town, or Location of Death California	4c. County o	
Funeral	Social Security Number	7 Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs		9 Birthplace (State or
Director	415-74-2276 IX	л 2□F 53	Yrs. Months Days Hours Min	04/28/1953	Country) Alaska
	Usual Residence of Decedent			1 04/20/1775	I Alaska
w any	10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
-f sho	Maryland St. Mary	/'s	California		1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number		10f. Zip Code	10g. Citizen of Wh	at Country?
ith the 23a c	23415 South Patux	ent Beach Road  12. Was Decedent Ever in U.S.	20619  13. Was Decedent of Hispanic Origin? ( Sp	United 14 Bass	States - American Indian, Black
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hard Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 X Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
F. or	3 Widowed 4 Divorced	1 X Yes 2 No i Yes, Give Year	1 Yes 2 X No specify:	Specify:	White
ours aft atural" canine	15. Decedent's Education (Specify only		ecedent's Usual Occupation (Give kind of v	vork done 16b Kind of Bu	
5-0036 led within 72 hour tygiene other than "natu the Medical Exan	Elementary/Secondary (0-12)	College (1-4 or 5+)	uring most of working life. DO NOT use reti	rea)	
5-0036 Jed within 7 Hygiene other thau the Medica	12	Na Na	<u>vigational Engineer</u>		ent of Defense
215-1 be filed ntal Hyg rked ott ent, the	17. Father's Name (First, Middle, Last)	T T T		(First, Middle, Maiden Surname)	
212 212 Ment Ment mark c even	Louis Hicks Mont	e, Print ) 19b.	Mailing Address (Street and Number or F	ty Broaden Rural Route Number, City or Town	n. State. Zip Code)
MD 2 show alth and ? m 27 is raumatic	Phillip W. Nordber	g / Friend 43	930 St. Andrew's Ch	urch Road, Cali	fornia, MD
Fe, I	20a. Method of Disposition	20b. Place of	Disposition (Name of cemetery, by or other place)	Date 20c. Location -	City or Town, State
MOI Pages ent of int: 1	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Tremoval non otate	· · · · · · · · · · · · · · · · · · ·	-9-2006 Charlot	te Hall, MD
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner.  To Be Completed by F	21. Signature of Funeral Service License		22. Name and Address of Facility Br	insfield Funera	1 Home, P.A.
<b>M</b> 8.0 <b>E</b> E	Kyle S. Simons	MU1206	22955 Hollywood Ro	ad, Leonardtown	, MD 20650-027
Physician	23a. Part I. Enter the disease, or compfice failure. List only one cause on each	ations that caused the death. Do not line. Atherosclerotic	enter the mode of dying, such as cardiac o cardiovascular disease of	r respiratory arrest, shock, or hea complicated by mixe	Approximate Interval Between Onset and
Examiner			etiaptine and dizepam)		Death
	b	ue to (or as a consequence of).			
ner		ue to (or as a consequence of);			
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):			
nd ransit	events resulting in death) Last D	ao to (or ao a comboquomos or),			
e be executed ysician and burial - transit	X UNPENDED	AMENDED #23a 27 28a-f	perME,g861,11/9/06 TT		
Box 68760, e death certificate be the attending physic ed for use as the burn hysician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy	perin, goor, 11/9/00 11	23d Date of	delivery
ox 6876 cath certificat attending ph. ior use as the	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2  4 Pregnant at time of death	Fetal death 3 Ectopic pregna	ncy Month	Day Year
Box 6876 he death certificate he attending phy hed for use as the b	1 Yes 2 No 9 Unknown	9 Unknown	Other (Specify)		
O. Bo at the de: 1 by the a lached fo	Part II. Other significant conditions	ontributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contri	oute to the cause of death?
res that the signed by be detack				1 Yes 2 No 3	Probably 4 Unknown
rds requi					Vere autopsy findings available rior to completion of cause of
Records, The law requires are has been signage 2 should be ompleted				performed? d	eath?
of Vital Records, P.O. ing Physiciau: The law requires that the After this certificate has been signed by huneral director, page 2 should be detact on: To Be Completed by P.	25. Was case referred to medical		26 Place of Death (Check		V 100 2 100
Vita	examiner?  1 Ves 2 No	spital: 1 Inpatient 2 ER/Out	patient 3 DOA Other Nursin	g Home 5 Residence 6	Other: Scene
n of V	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. T	me of Injury 28c. Injury at Work?	28d. Describe how injury occurre	ed
trend death tor: y the f	Natural 5 Pending Accident Investigation	Fnd 10/1/2006 Fnd	11:00 am 1 Yes 2 X No	unknown	
Division o ospital or Attending hours after death meral Director: Aft y filled in by the fun Certification:	3 Suicide 6 X Could not be		m, street, factory, office building, etc	28f. Location (Street and Number or Jown, State) 23415	or Rural Route Number, City
Dospita hours y fille	4 Homicide determined  29a Certifier 1 Certifier Physicial	(Specify) found at 1		Beach Rd. Califor	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	one) 2 Medical Examiner:	On the basis of examination and/or in-	h occurred at the time, date and place, and restigation, in my opinion, death occurred a		
Me Service Ser	29b. Signature and title of certifier	nd manner stated.	29c. License number	29d Date signe	d (Month, Day, Year)
	Las La Gree	nhy Mp	O.C.M.E.	October 2,	2006
	30. Name and address of person who co				
	Tasha Greenberg MD. As	ssistant Medical Examiner	111 Penn Street, Baltimore, MD	21201	
State	31. Date filed (Month, Day, Year) OCT 1 2 2006	32. Registrar's Signature	<i>N</i> -		
Registrar	UUI - 4 2006	Dien A Age			
DHMH 17 Rev 1/2001		ORI	GINAL		

State of Maryland / Department of Health and Mental Hygien 32931 Certificate of Death 2. Date of Death
Month Day
October 8 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Edna Martin 2006 9:25 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mennonite Home Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nin. | August 1 / 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 90 215-64-2460 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then \*natural', or Items 23e or 28e-f show the Medical Examinar must be notified at MD. Washington Hagerstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13436 Maugansville Rd. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John H. Diller Maggie Mae Strite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathan Diller /Nephew 21619 Chewsville Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cometery, crematory or other place)
Reiff Mennonite Church
Cemetery Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/12/06 Cearfoss, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician /Medical Due to (or as a consequence of): Examiner inbet Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine I Hecords, P.O. Box 68760, physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as I attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐ Pregnant at time of death signed by the all d be detached for 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> should be 1 ☐ Yes 2- TNo 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **N**O or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Blod JELFRESDA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	state of Mary		artment of H			giene 200	6 32932
	Physici /Medi		Decedent's Name (First, Middle, Last)     James Richard	Miller				2. Date of Dea	Day Year	e 1545 M
	Examir Funeral Director	ner	2 00 000	ck Can	n pus n yrs. last birthday) Yrs.	4b. City, Town, or  If Under 1 Year  Months Days	Location of Dea  Crac Care  If Under 24 Hrs  Hours Min	d	4c. County of Dea Allega h Year 1957 Wes	
	Maryland I-1 ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD. Allegany	10	c. City, Town or Lo Barton					10d. Inside City Limits 1 ☐ Yes 2 📉 o
	th with the 23a or 28s	al Director	10e. Street and Number 24115 Kyle Hill Re	oad		10f. Zip Code 21 5	521		10g. Citizen of What C United Sta	
900	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deparantent of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-1 ehow spirioury or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral	11. Marital Status 12.  1	Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decedent of Hi if Yes, specify Cuba 1 ☐ Yes 2XXIIo	spanic Origin? (Spanic Origin? (Specify:	Specify Yes or No- to Rican, etc.)	Black, Wh	
Maryland 21215-0036	ed within 72 h giene. er then "netu . the Medica	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12	on ompleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired ir Tender	ation furing most of wo )	orking	Bar/Tave	
yland	should be file and Mental Hy s marked oth umatic event	To Be (		ller			Bett	y Kyle	Maiden Sumame)	
	1 and 2 shi fealth and im 27 is m ther traum		19a. Informant's Name/Relationship (Type, Betty Miller/ mothe	r	2411	5 Kyle Hi		, Barton	, City or Town, State, Maryland	21521
Baltimore,	it. Pages intment of h intent: If its njury or of		20a. Method of Disposition  1  Burial 2  Cremation 3  Rem 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee	aval from State	Laurel Hi	natory or other place II Cemete	ery 20		Barton, Ma	
Ba	permit. Depart Import eny inji		7-Varge  23a. Part 1. Enter the disease, of complicat	Gal the caused the	1	11 Church	st., W		rt, Marylar	nd 21562
j	Physician /Medical Examiner		shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Se in each line.	mant	Lyn	mpho.	ma	1651,	Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co		/				
68760,	icate be executed physician and s the burial-transit	dicai	d	Due to (or as a co	msequence or):		-			
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p 1□Live birth 2 □ 4□Pregnant at time 9□Unknown	Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ords, P.	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the ur	nderlying cause give	n in Part I.		obacco use contribute t 'es 2 ☐ No 3 ☐ P	o the cause of death?
Vital Records,	The law ete has b page 2 si	Completed						24a. Was a autop. perfor	an 24b. Were a prior to death? 2 No 1 Yes	utopsy findings available completion of cause of s 2 No
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Tyes 2 W No Hos	ntal: 1 npatient	2 ER/Outpatien	t 3 DOA Othe		ath (Check only or	ne) ence 6 ⊡Other (Spe	7.1
Division of	iding Phy th. : After this funeral o	on: To		8a. te finjury Month, Day Ye					ow injury occurred	eciry)
<u>S</u>	r Attanding er death. rector: After by the funer	catic	Accident investigation			M 1 🗆 Y	res 2 □No			
DIX	ital or Attandi urs after death ral Director: A lled in by the f	Certification:	4 Homicide determined	8e. Place of Injury building, etc. (S	pecify)			City or Tow		
	To the Hospital or I within 24 hours after To the Funeral Direcompletely filled in b	Medical	(Check only one)	On the basis of exa and manner stated.	y knowledge, death imination and/or inv	estigation, in my op	oinion, death occi	urred at the time, o		e to the cause(s)
	wit T or		29b. Signature and affle of certifier  30. Name and address of p. n. ho	ted cause of death	(Item 23a), yng	29c. License	0154	63	October	) 9, 2006
		5	DR. ShiN Kim	90 MAI	N/Stre	et, We	Sterni	DORT, N	10 2156	2
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 20	32. Registrar's S	Signature	Lesk o	,			

			1 - For State Registrar	State of I	Marylar				ealth a D <i>eath</i>	ind M		giene Reg. No.	006	32933
	Physici	an	1. Decedent's Name (First, Middle, Las	,							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		William Harolo		JR						OCTOBE	R 6	2006	0555 M
	Examir	er	4a. Facility Name (If not institution, give MEMORIAL HOSPITAI		er)			, Town, or BERLA	Location o	f Death			County of Death EGANY	
	Funeral		Social Security Number 6. Se	9x 7.	Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 2		8. Date of Bird (Month, Da		9. Birth	place (State or Foreign
	Director		219-32-0019	<b>∑</b> ₩ 2 ☐ F	56	Yrs.	Months	Days	Hours	Min.	April 8	195	0 West	Virginia
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation	···-						10d. Inside City Limits
	Mary -f eh	tor	MD. Allegar	ny		Wester	nport							1 ☐ Yes 2√∑ No
	or 286	Director	10e. Street and Number				10f. Zij	Code				10g. Citize	en of What Cou	ntry?
	ath w	rai		nd Drive				2156					ted Sta	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or freme 23e or 28e-1 ehow other traumatic avent, the Medical Exeminer maint be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	12. Was Decede Armed Force 1 ☐ Yes 25 If Yes, Give Year or Date	s? ⊒X <sup>N</sup> º	'	Was Dece fYes, spe 1 ☐ Yes	cify Cuba	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White Specify: Wh	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	kind of wo	ork done d	uring most	of worki	ng	16b. Kind	d of Business/Ir	ndustry
121	within	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		oo not u erato	ise retired,				Co	oal	
d 2	Hygie Sther ant, III		12 17. Father's Name (First, Middle, Last)			- Op.		) <u>.</u>	18. Mothe	r's Name	(First, Middle,	Maiden S	'umame)	
<u>lan</u>	Aental Aental rked tic av	ТоВе	William Harold	d Moran	SR				Ma	ry	Ellen	Kenny	У	
Maryland	2 sho and h ls ma	ġ l	19a. Informant's Name/Relationship (7								I Route Numbe			
e,	1 and Heelth em 27 ther to		Lucille Moran/ Wi	ie.	20h	2522 <sup>4</sup> Place of Dispo			d Dri		Westerr		, Maryl. ation · City or T	and 21562
nor	ages ant of it: If It y or o		Washing of Proposition 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te .	cemetery, cren	natory or o	other place		10/	09/			Maryland
altimore,	permit. Pages 1 an Department of Heel Important: If Item 2 eny injury or other soce.		21. Signature of Funeral Service Licens		7				s of Facility	200	6 al Fune			
<u> </u>	Depa Impo eny ii		7 Ways	e Bal		11	11 Ch	urch	St.,	Wes	ternpor	t. Ma		21562
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each	ed the dea line.	th. Do not ente	,	0						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metc	ISta	tic I	Vor	Sn	rall	cel	1 Lu	19 (	arci	noma
	Examiner			Due to (or	as a consec	quence of):								
	T .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consec	дивпсе ођ:				-				
	icate be executed physicien end s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	35 3 50850	ruanca of):								
8760,	sicien buria	aiE		200 00 (0)	15 & CONSEC	querice or).								
687	tificate ig phys as the	edicai		d										
. Box	ndir use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcor 1 □Live birth 4 □Pregnant 9 □ Unknowr	2 Feta	el death 3	Ectopic p Other (sp					23	d. Date of deliv Month	ery Day Year
P.0	that the death ed by the ette detached for	Phys	9 Unknown											
ords,	w requires the been signed should be de		Part II. Other significant conditions co	ntnbuting to deatr	Dut not res	sulting in the ur	iderlying o	ause give	n in Part I.					he cause of death?
		Completed									24a. Was autop perfor 1 Yes	med?	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hanrital.				100		of Death	(Check only o	пе)		
o	₽ = B	5	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien			4 🗀 1401		ne 5 Resid			5)
on	Attending Phyrdeath.  actor: After thi by the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of II (Month, I	ay Year)	Injury	м	28c. Injury Work 1 □ Y	? es 2□N		. 50001150 1	ow injury c	00001180	
Divis	al or Atter efter des I Diractor d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	njury - At h etc. <i>(Speci</i>	ome, farm, stre fy)	eet, factor	y, office		2	28f. Location (S City or Tow		Number or Rura	al Route Number,
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medicai C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the be iner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred	at the time, in my op	e, date and inion, deat	place, a	and due to the dead at the time, d	cause(s) ar	nd manner as s lace, and due t	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	and			290	. License	number			29d. Date :	signed (Month,	
)				-CIV	V		D	2337	L			oct	6	, 2006
		10	30. Name and address of person who c				•			0				
	Sta	Q/	QAMAR ZAMAN, M.D.  31. Date filed (Month, Day, Year)	625 KE 32. Regi	NT AV		UMBE	KLANI	), MD	215	02	-		
	Registr			2006	Q.,		Locali	2 0						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32934 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55 PM SEPTEMBER 29 2006 DOROTHY ELIZABETH MCCLYMENT /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAROLINE HOME HOSPICE DENTON CAROLINE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2**X**F Months Hours Min. Yrs MD 85 08/30/1921 Director 213-14-7706 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo QUEEN ANNE'S MD GRASONVILLE 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 300 CEMETERY ROAD 21638 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced WHITE "natural", Completed ar than "natur. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked ADDISON MASON GOLDIE SUMMERS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at important: If item 27 is any injury or other treu page. ROBERT W. MCCLYMENT / HUSBAND 300 CEMETERY RD., GRASONVILLE, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 10/04/2006 CENTREVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address FELLOWS, HE HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 400 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dim /Medical Due to (or as a consequence of): **Examiner** 00018 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign 1 be 2 XNo 3 Probably 4 Unknown 1 TYes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient Other: ě 2 1 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After ! Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Dey, Year) MPH completed cause of death (Item 23a) (Type Print) nd address of person w APRICIA 130 Live PARd Suit 31. Date filed (Month, Day, Year) State 2006 OCT Registrar

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** AM MABLE GRACE MENCH 3:32 SEPTEMBER 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 😿 F Yrs. Director 217-36-1520 68 12/20/1937 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow the Medical Examiner must be notified at Directo 1 ☐ Yes 2 No MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 117 PIER AVENUE 21666 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced "natural". WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental H JOHN WESLEY PEARSON MARY WALLS permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ls m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN TIMMS / DAUGHTER 416 RAILROAD AVE., CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/03/2006 STEVENSVILLE, MD 21. Signature of Foneral ervice Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. 23a Part1 Enter the Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Respiratory Insuluine Physician Weeks /Medical **Examiner** Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.O. I 4☐Pregnant at time of death the a 9 Unknown 9 Unknown 3 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Ď 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) Day, Year) 21438 o completed cause of death (Item 23a) (Type, Print) La Penta 445 DEFENSE HIGHWAY ANNAPOLIS, MD 21401 MICHAEL J. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Wen It Sport Registrar

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artmer rtifica	nt of H te of L	ealth a	and N	lental Hy	giene Rag. No.	200	6	3293	36
ı	Physici	an	1. Decedent's Name (First, Middle, L.  Nancy R.								2. Date of De Month Septem	Day	28 2	ar 206	3. Time of Dea 2:00 P	ath M
	/Medio Examir		4a. Facility Name (If not institution, gi 8034 Park Lane		•			Town, or	Location o	of Death	Берсеш	4c.	County of Contgo	Death		
	Funeral Director			Sex 7. Ag 1 □ M 2 💢 F	69 (In yrs. I	last birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Feb. 9	y, Year)		Coun	ace (State or Fo try) achusett	_
	72 hours atter death with the Maryland natural', or iteme 23a or 28a-1 ehow dissal Exac-linar roual be recified at	rector	10a. State 10b. County Maryland Montgon 10e. Street and Number	ery	'	y, Town or Lo		o Code				10g Citi:	zen of Wha		Od. Inside City Li	
	th with 23e or	ai Dli	8034 Park Lane				101. 21		20814	ł		rog. Oiti	U. S			
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show among injury or other traumatic event, the Medical Exercitational be notified at ADGS.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:			Was Dece II Yes, spe 1  Yes			gin? (Sp , Puerto	ecify Yes or No Ricaл, etc.)		8 Black, \Specify:	White, e	etc.	
1215-0	within 72 h ane. than "natu	mpletec	15. Decedent's E (Specify only highest gi		i+)	lile.	kind of wo DO NOT L	ork done d ise retired,	urina most		ing	16b. Kir	nd of Busin			
Baltimore, Maryland 21215-0036	uld be filed Jental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Las Stanford Gold	")					18. Mothe	r's Nam	e (First, Middle, hy Isra		Sumame)			
, Mary	and 2 sho lealth and h m 27 is me		19a. Informant's Name/Relationship Ralph J. Nossal		Tast 5	8034	Park	Lane		thes	da, Mar	ylan	d 208	14		
timore	. Pages 1 Iment of H tant: If ite jury or oti		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Speci	fy)	C	lace of Dispo emetery, crer klawn	Ceme	other place tery	10	0/1/	2006	Roc		e, l	Maryland	i
Ball	Depart Depart Import any in		21. Signature of Funeral Service Lice	$\widehat{\mathbf{T}}$							Memoria , Rockv		apels , Mar	, In	ACT OF THE OWNER OWNER OF THE OWNER O	52
	Physician /Medical Examiner	Examiner	23a. Pant1. Enter the disease, or conshock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Hepat:	ic Fa a consequ tatic	ilure uence of): : Adenc					11.	rrest,			Approximate Interval Between Onset and Deat	
Box 68760,	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit	edicai	IF FEMALE: 23b. Was decedent pregnant	Due to (or as d	of pregna	псу _						2	3d. Date of	deliver	у	
P.O. B	of the death by the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic p Other (s)						Month		Day Year	
	w requires the been signed I should be det	Ď	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the u	nderlying	cause give	n in Part I.						a cause of death ably 4 ⊟Unkn	
Division of Vital Records,		Completed	A .										24b. Wer prior deat 1 🗌	h?	sy findings avai pletion of cause	lable a ol
l Vit	Physician: this certifice ral director, p	To Be	25. Was case referred to medical examiner?  N□ Yes 2□ No	Hospital:	nt 2 🗆 I	ER/Outpatien	t 3 🗆 DX	Othe	C.		n <i>(Check only o</i> me 5 <b>X</b> ] Resid		Other (	Specify	}	
sion of	To the Hospital or Attending Physician: Within 24 hours alter death. To the Funaral Director Affer this certific completely filled in by the funeral director.	Certification: 7	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	v	28b. Time of Injury		28c. Injury Work			28d. Describe l			opoony,	,	
Divi	oital or Att urs atter d iral Direct		3 Suicide 6 Could not to determined	building, etc	: (Specify	<i>'</i> )					28I. Location (5 City or Tox	vn, State)				
	To the Hospital of within 24 hours all To the Funaral D completely filled in	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of minar: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, th occurr	and due to the e ed at the time,	cause(s) a date and	and manne place, and	r as sta due to	ited. the cause(s)	
)	. 1	Me	29b. Signature and title of certifier  Robbert	Mari	-		2	c. License .1025	литber				signed (M 29-06		Day, Year)	
1-	3		30. Name and address of person who Robert D. Warren	•				NW Wa	shing	gton	, DC NW	200	07			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	006 32 Registra	_	ture	RAPE)									

			1 - For State Registrar		/larylar	nd / Depa <i>Cer</i>	artmer tificat	nt of H	ealth a Death	and M		gienez 0 ()	
	Physici /Medic		Decedent's Name (First, Middle, Last     THIEM MAI NGI	) J <b>YEN</b>							2. Date of Dead Septem	ber 29, 2	3. Time of Death 2006 10:50P M
	Examir		4a. Facility Name (If not institution, give Shady Grove Adver			L		Town, or	Location o	f Death		4c. County of	
	Funeral Director		5. Social Security Number 6. Se			last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Dec • 1		D. Birthplace (State or Foreign Country) /ietnam
	Ra-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Md. Montgome	ery		ty, Town or Lo Gaither	sbur		,				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with th	al Dire	10e. Street and Number 9121 Roundleaf Way	7			10f. Zij	Code 20	879			10g. Citizen of Wh	•
920	72 hours after death with the Maryland natural', or Iteme 23s or 28s-f ehow Jical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	? ] No	11	Vas Dece Yes, spe	cify Cubar	spanic Origin, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	- 14. Race -	American Indian, White, etc. Asian
21213-0030	be filed within 72 hours after death with the Marylan tat Hygiene. Id other than "natural", or fleme 23s or 28s-1 show event, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	16a. Deced (Give life. L	kind of wo	ork done di ise retired)	tion uring most	of workin	g	16b. Kind of Busin	•
yland	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Kham Dang Mai							r's Name Thu P		Maiden Surname)	
Баппоге, магу	alth and A		19a. Informant's Name/Relationship (7) Mai Chi Nguyen (Da	•			_					rg, Md. 2	
	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic and DEC.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		<b>6</b>   _	Place of Dispos cemetery, crem te of H			n.	Oct 2006	3,	20c. Location - Ci	ty or Town, State Spring, Md.
Dail	permit. Departr Imports eny Inju		21. Signature of Funeral Service Licens  Cuttus E. C.	lay.		1	Name a	nd Address st De	s of Facility er Pa	DeVol ark D	l Funer r. Gai	al Home thersburg	, Md. 20877
F	Physician by American and physician and physician streaminer some streams the purial-transit	dical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of timediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each	s a conseq	ULEST (uence of): 20MA (uence of):						LURE	Approximate Interval Between Onset and Death
O. BOX 0	the death certifii y the ettending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	ıldeath 3□	Ectopic p Other (sp		.,,			23d. Date of Month	
COLUS, T	quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the un	iderlying o	ause give	n in Part I.		23e. Did to		ute to the cause of death?
וומו חבכם	n: The law re licete has bee r, page 2 sho	Completed								_	24a. Was a autop perfor	sy prio	re autopsy findings available in to completion of cause of th?  Yes 2 No
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after feath.  To the Funetal Director: After this certificete has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury a <i>y Year)</i>	ER/Outpatient 28b. Time of Injury	M	Other 28c. Injury Work'	r: 4 □ Nur	rsing Hom		ne)  dence 6 Other now injury occurred	
2	pital or At ours after d braf Direct illed in by		4 Homicide determined		etc. (Specif	(y) 					City or Tow	n, State)	or Rural Route Number,
	thin 24 ho thin 24 ho the Fun mpletely f	Medical	29a. Certifier (Check only one)  T Certifying Physical Examions  T Medical Examions  29b. Signature and title of certifier	ner: On the basis and manner s	of examina	owledge, death tion and/or inv	estigation	at the time i, in my opi c. License	nion, death	d place, ar h occurre	d at the time, o	cause(s) and manndate and place, and 29d. Date signed (8	due to the cause(s)
	F 3 F 8		•	m.					E 5	7/2		9/30	* '
-	5		30. Name and address of person who or Dr. Truong Bao M.D	. 9715	Medic	al Cent	er D		201	Rockv	ville,	Md. 20850	)
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signa	B. So	arti	,					

			PR			artment of Health ar		_
			1 - State Registrar	Olato o		ertificate of Death		og. No2006 32938
	Di		1. Decedent's Name (First, Mi	iddle, Last)			2. Date of Dea Month	th 3. Time of Death
	Physici /Medi			Radcliffe	Orem		Sept	29 2006 10 SOM
4	Examir	ner	4a. Facility Name (If not institu		nber)	4b. City, Town, or Location of I		4c. County of Death
H	Funeval		5714 Beach 5. Social Security Number		7. Age (In yrs. last birthday	East New M		Dorchester  9. Birtholace (State or Foreign
	Funeral Director		217-30-3896	1 <b>万</b> M 2□F	71 Yrs.	Months Days Hours	Min. 8. Date of Birth (Month, Day) Aug. 2.	Year) 9. Birthplace (State or Foreig Country) Maryland
,	pug 💃		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or L	ocation		10d. Inside City Limit
L	Maryla f sho	ō		orchester	loo. Only, rount of C	East New M	arket	1 Tyes 2 XN
3	the Program	rect	10e. Street and Number			10f. Zip Code		0g. Citizen of What Country?
3	after death with the Maryland or Iteme 23e or 28e-f show miner must be marified at	al D	5714 Beach	Haven Road		21631		USA
0	r dea	ner	11. Marital Status	Armed For	ident Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after turel', or Ite	by Fi	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 🖼 Divore	If Yes Giv	9 4055 77	1 ☐ Yes 2 X No Specify:		Specify: white
21215-0036	2 should be filed within 72 hours and Mental Hygiene. Ie marked other then "neturel", aumatic event, It e M. Jical Ex.	Completed by Funeral Director	15. Dece	dent's Education		edent's Usual Occupation		16b. Kind of Business/Industry
215	within 72 ene. then "net	nple	(Specify only hig Elementary/Secondary (0-1)	phest grade completed)  2) College (1	-4or 5+) (Give	edent's Usual Occupation a kind of work done during most o DO NOT use retired)	f working	
	filed wi Hygien sther th	Con	12		po	stal worker		U. S. government
and	if be fi	Be	17. Father's Name (First, Midd				Name (First, Middle, I	,
Maryland	2 should be f and Mental I le marked of aumatic eve	7	Reginald Ca		19b. Mail	ing Address (Street and Number of	el Robinsor	
	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygiene. If item 27 le marked other then "naturel", or Iteme 23e or 28a-f show or other traumatic event, ir a Madical Examinet mast be natified at		Michael Orem			Pepper Tree Co	30	SECTION 1
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr once.		20a. Method of Disposition  1 Surial 2 Crematic		20b. Place of Disp	osition (Name of matory or other place)		20c. Location - City or Town, State
Ë	nit. Pages partment of l cortant: If its injury or o		'4 □Donation 5 □ Other		Christ C	hurchyard 1	0/4/06	Cambridge, MD
3all	permit. Departr Imports eny inju		21. Signaturi of Funeral Servi	ice Licensee		2. Name and Address of Facility		
	495.00		23a Part (Enter the disease	or complications that or		700 Locust St.,		
			shock, or heart failure. I Immediate Cause (Final	ist only one cause on ea	1	ter the mode of dying, such as ca	4	Interval Between Onset and Death
	Physician /Medical	Ì	disease or condition resulting in death)	a. Due to (	or as a consequence of):	genous her	chemy	18 mos
В	Examiner		Sequentially list conditions	b				
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequence of):			
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a consequence of):			
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	calE						
68	uficate g phy as the			d.				
Вох	th cert lendin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy rth 2  Fetal death 3[	□Ectopic pregnancy		23d. Date of delivery
-	e dea the at hed to	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of death 5	Other (specify)		Month Day Year
P.0	that the de led by the a detached t	Ph)	Part II. Other significant cond	litions contributing to de	ath but not resulting in the u	Inderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
Records,	uires tha signed	d by		Depud	/ \ /	ly	1 □ Ye	s 2 3 Probably 4 Unknown
00	s been si should	Completed		/			24a. Was a	
Re	The lav	mo	-				— autops perform 1 ☐ Yes 2	y prior to completion of cause of death?
Vital		Be C	25. Was case referred to med examiner?			26. Place of	Death (Check only on	
of V	Physicien: this certificatel director,	္ပ	1 ☐ Yes 2 ☐ No		patient 2 ER/Outpatie			nce 6 Other (Specify)
	ftel ne	tlon:	27. Manner of Death  1 ■ Natural 5 ■ Pen	iding	of Injury 28b. Time of Injury Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred
Division	eat or:	fical	3 ☐ Suicide 6 ☐ Cou	estigation uld not be ermined 28e. Place	of Injury - At home, farm, st			reet and Number or Rural Route Number,
Ö	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Certification;	4 Homicide	buildin	g, etc. (Specify)		City or Town	, State)
	To the Hospitel or within 24 hours afte To the Funerel Dit completely filled in	edical (	29a. Certifier 1 Certifier (Check only 2 Medic	ying Physician: To the	best of my knowledge, deal	h occurred at the time, date and p	place, and due to the ca	use(s) and manner as stated. Ite and place, and due to the cause(s)
	To the H within 24 To the F complete	Medi	one)	and mann	er stated.	29c. License number		
V.	70 Witi	-	29b. Signature and title of cert	Polev 1	110-5			Od. Date signed (Month, Day, Year)
L.,	100		30. Name and address of pers			D2638	0	c1, L, L006
			Michael J	Frelden		Mins Hurlock	E md 216	43
	Sta	- 3	31. Date filed (Month, Day, Ye		ogistrar's Signature	1		
	Registr	ar	oci	9 3 2006	Regue De	Good		

State of Maryland / Department of Health and Mental Hygien 2006 32939 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 4:50 P M Randolph Plummer Owens October 8, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Allegany Frostburg Village Nursing Home 8. Date of Birth (Month, Day, Year Feb. 1, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 **№** M 2 🗆 F 577-10-1522 90 1916 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "naturet", or itams 23s or 28s-f show other traumatic event, the Modical Exemples must be notified at Prince Georges MD. Upper Marlboro tXXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 18107 Central Ave. United States deeth v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: if item 27 is marked other than "natural", or its 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Transit System College (1-4or 5+) Elementary/Secondary (0-12) Bus Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Randolph Owens SR Antoinette Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Owens/ son 2001 Hideout Lane, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 20a. Method of Disposition 10/09/ 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Maryland permit. Page. Department o tmportant: if i any injury or once. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Aspivation **Physician** days /Medical Due to (or as a consequence of): Examiner Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan page 2 s Hypertension certificete ormea? 2**\**√No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director, Be 25. Was case referred to medic examiner? 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 214464 09 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S L Sandhir 48 Tarn Terrace, Frostburg, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 10 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death

**Physician** Jean Pence Oct. 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 578-30-4903 1 □ M 2 1 F Hours 81 Director July Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 9701 Veirs Drive 20850 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Be and Mental H Otto H. Pence Eleonora 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai Kristina Hughes-Executor 20b. Place of Disposition (Name of 20a. Method of Disposition Date Emmanuel Luth Cem 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications, or heart failure. List only one ications it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cinsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Brain Tumor Chronic Respiratory Failure 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P Certification: 5 Pending investigation (Month, Day Year, 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a **To the Funeral** I 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

1. Decedent's Name (First, Middle, Last)

23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 10/3/2006

State Registrar 29b. Signature and title of certifier

Dr.

31. Date filed (Month, Day, Year)

0 4 2006

shama

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Gard

DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

3. Time of Death

2006

3:00aM

4c. County of Death

Montgomery Co.

 Birthplace (State or Foreign Country) 27,1925 Wash.,DC

> 10d. Inside City Limits ¥☐Yes 2☐No

10g. Citizen of What Country?

USA Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

At Home

18. Mother's Name (First, Middle, Maiden Surname)

R. Henkle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701- Veirs Dr., Rockville, Md. 20850

20c. Location - City or Town, State 10/5/2006 New Market, Va.

Hysong Company, Inc. - 2222 Wisconsin Ave

Washington, DC Interval Between Onset and Death

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29c. License number

D60826

- Holy Cross Hospital 32. Registrar's Signature

			1 - For State Registrar	State of Marylar		ent of Health and ate of Death		giene 006	32942
	Physici	4	1. Decedent's Name (First, Middle, Last	1 1	u halla	4	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	Street and number) Memorial H	DSNIED 46.0	ity, Town, or Location of Do Oak land der 1 Year   If Under 24 F	eath	4c. County of Dea	ett
	Funeral Director		5. Social Security Number 6. Sec. 176-34-0189 Usual Residence of Decedent	7. Age ( <i>In yr</i> s.	Yrs. Mont		lin. (Month, Day		thplace (State or Foreign ountry) ennsylvania
	Maryland -f show	tor	10a. State 10b. County PA Alleghe		ty, Town or Location orth Versa	illes			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number  1412 Luehm Avenue		10f.	Zip Code 15137		Og. Citizen of What Co	
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if itam 27 is marked other them "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exagence must be troubled at 8a. 8a.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pus 2 X No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit	ncan Indian,
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		life. DO NO	work done during most of t Tuse retired)		16b. Kind of Business	
	ould be filed within Mental Hygiene. arked othar than " atic evant, the Me	Be	17. Father's Name (First, Middle, Last)	Z	Sales I	_	Name (First, Middle,	Retail : Maiden Sumame) Davis	sales
Maryland	d 2 should th and Men 7 is marke traumatic	T <sub>o</sub>	Larry  19a. Informant's Name/Relationship (7)		_	ess (Street and Number or		r, City or Town, State, 2	
	Pages 1 and inent of Health int: If item 27 iry or other tr		Mrs. Carol J. Puh 20a. Method of Disposition 1 Burial 2 Cremation 3 X	20b. F	Place of Disposition ( cemetery, crematory	or other place)	Date	20c. Location - City or Braddock H	Town, State
Baltimore,	permit. Pages 1 ar Department of Hea Important: if itam any injury or othe once.		4 □ Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens				Burdock-Du	rst Funera	1 Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death)	ilications that caused the deat ine cause on each line. a	Moca	node of dying, such as card	ntave		Approximate Interval Between Onset and Death
8760,	cate be executed ohysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	boue to (or as a conseq.cDue to (or as a conseq.d.		VO[ 1 C CO V	chargu	sease	opers.
O. Box 6	the death certificity by the attending pached for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	al death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of del Month	ivery Day Year
rds, P.	quires that in signed t uld be det	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	~
Il Records,	The law requir cate has been si page 2 should	Completed					24a. Was a autops perfort	y prior to	topsy findings available completion of cause of
of Vital	ding Physician: The h. h. Atter this certiticate ha tuneral director, page	: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2	NER/Outpatient 3□	DOA Other: 4 Nursing	7.	e) ence 6 □Other (Specow injury occurred	city)
Division	Attanding For death.  Sector: Atter by the tuner.	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury M ome, farm, street, fac	28c. Injury at Work?  1 Yes 2 No		treet and Number or Ru	ıral Route Number.
Div	in Dir	al Certi	4   Hornicide	building, etc. (Specifican: To the best of my kno	fy)		City or Town	n, State)	
	To the Hospital within 24 hours of To the Funeral I completely tilled	Medical	(Check only one)  2 Medical Examination (Check only one)  29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion, death o	ccurred at the time, d	ate and place, and due	to the cause(s)
	⊢ s ⊢ ŏ		Paul Dans	Amller &	<i>S</i> o	176154		10/03/0	06
			Paul Duviel Milk	ev DO 69 Wo	m 23a) (Type, Print)	29c. License number H 26154 S Dv. Gukl	and, u	ND 215	20
*	Sta Registi		31. Date filed (Month Pay Year) 5	2006 32. Registrar's Signa	ature	£ .0			

			1 - For State Registrar		partment of Health and Mertificate of Death		ne N2006	32943
	Physic		1. Decedent's Name (First, Middle, Last,  Beatrice Mary			2. Date of Death Month October	Day Year 4 2006	3. Time of Death 3:05 A M
	/Medi Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		Homewood Retirem 5. Social Security Number 6. Security Number 170, 20, 9767	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	Washin	ngton place (State or Foreign intry) Virginia
	pu »		179-20-8363  Usual Residence of Decedent  10a. State 10b. County	81 Yrs.	Location	Feb. 2, 1		10d. Inside City Limits
	death with the Maryland me 23s or 28s-f show Errust be nutited at	Director	West Virginia Berke	eley	Martinsburg 10f. Zip Code	10g.	Citizen of What Cou	1 ☐ Yes 2 🛣 No
036	or ite	by Funeral	8 Regiment Lane  11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 X 0 If Yes, Give Year or Dates:	25401 3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ocify Yes or No- Rican, etc.,	USA  14. Race - Amer Black, White Specify:	ican Indian,
215-0		Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. Dec (Giv   College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of worki . DO NDT use retired)	ng 16b	. Kind of Business/Ir	ndustry
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 le marked other then "reumatic event, to Max	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		sing
aryla	should nd Mer marke	J.	George Fitzwate  19a. Informant's Name/Relationship (Ty		Laoda Iling Address (Street and Number or Rura		ndy v or Town, State, Zi	p Code) OF 440
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene important: If item 27 ie marked other then "natuenty injury or other traumatic event, ta Mudical once.		Sharon Resh - Dau  20a. Method of Disposition  1 Burial 2XX remation 3 B  4 Donation 5 Other (Specify)	ghter 297  20b. Place of Dispersion State	Weeping Willow Rd.	Falling Pate 20c.	Waters, W Location - City or T	lest Virgini own, State
Balt	permit. Departi		21. Signature of Funeral Service Licent	0	รับชากับ ซีนักอาร์สาแฟome 25 S. Conococheague	, P.A.	rocco v societali.	21795
	Physician /Medical Examiner		23a. P.m. Enter the disease, or complishock, or high failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ele cause on each line.  Due to (or as a consequence of):	nter the mode of dying, such as cardiac of the state of t	r respiratory arrest,		Approximate Interval Between Onset and Death
8760,	sate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
O. Box 6	The law requires that the death certificat Ne has been signed by the attending phy page 2 should be delached for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		i⊟Ectopic pregnancy □ Other (s <i>pecify)</i>		23d. Date of deliv Month	ery Day Year
rds, P.	w requires that been signed t should be deta		Part II. Other significant conditions con Congostive hear				o use contribute to t	the cause of death?
of Vital Records,		Completed by	Arterorelesoti	tailure, Dona	decease	24a. Was an autopsy performed:	prior to co	opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death	(Check only one)		
of	ding Physician: h. After this certific funeral director,	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatie	of 28c. injury at 2	ne 5 Residence		(y)
Division	Attending I r death. ector: After by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	8f. Location (Street	and Number or Rur	al Route Number,
٥	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Cert	4 - Hottlicide	building, etc. (Specify)	ath occurred at the time, date and place, a	City or Town, Sta		tated
	the Ho hin 24 h the Fui npletely	Medical	one) 21 Medical Examir	ier: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date a	and place, and due t	o the cause(s)
	To vii	-	29b. Signature and title of certific		29c. License number  D26806		Date signed (Month,	
-			30. Nam as a ss on while co	mpl. se of death (Item 23a) (Type	D26806	) Ha	anda	MN 21742
	Sta	ite	31. Date filed (Month, Da., Year)	32. Registrar's Signature	I MINISIVENE D	the "the	or fruit	- CIP

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

		ricase i	State of Maryland	/ Donort	mont of L	looth and M	copies A	one Legiple.	32944
		1_ State	State of Maryland /	Oopuit	icate of	ioaitii ana iii	ornar riygi	ONO	
		1. Decedent's Name (First, Middle, Last)		007111		Dealit	2. Date of Death	g. No.	3. Time of Death
Physici		Marv Ka	THERINE Quand	9+-			Month 09	28 200	12 7 7 7
/Medio Examin		4a. Facility Name (If not institution, give s		1	o. City, Town, o	r Location of Death	01	4c. County of Dea	
		Coastal Hospice	at the lake	5	Salisb	un		Wicomic	20
Funeral		5. Social Security Number 6. Sex		M	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
Director		156-56-5838 Usual Residence of Decedent	48	Yrs.			11/12/19	957 New	Jérsey
land ow		10a. State 10b. County	10c. City, To	own or Location	on				10d. Inside City Limits
Man,	to	Maryland Wicomico	Sa	alisbur	CV.				1 □XYes 2 □ No
th the	lrec	10e. Street and Number			Of. Zip Code		10	g. Citizen of What Co	ountry?
th wil	Funeral Director	404 Moss Hill La	ne Apt. B		2180	01		USA	
r dea	nue	11. Marital Status	I2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was	Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto F	city Yes or No-	14. Race - Ame Black, Whit	
s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		Yes 2 No	Specify:			white
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland all hygiene. A the file with the Wedleal Examination of the modified and went. In Medical Examination of the modified and the modified	edt	15. Decedent's Educ	Year or Dates:	6a Decedent	's Usual Occup	ation	10	6b. Kind of Business	(Industry)
on 7 on and and and and and and and and and an	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind	of work done of NOT use retired	during most of working	g	DD. KING OF BUSINESS	industry
giene giene	Completed	12	2	Execu	tive Se	ecretary		Insuran	ce
al Hy al Hy	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name			
VICITY INTO TO INTO THE STORY INTO THE STORY INTO THE STORY INTO THE STORY INTO THE STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STEEL STORY INTO THE STORY INTO THE STEEL STORY INTO THE STO	ပ	Benjamin H. We					McElroy		
ie, wid yid it a Z IZ IS-0030  I and 2 should be filed within 72 hours after death with the Marylar ffeath and Mental Pygene.  I feath and Mental Pygene.  I feath and Mental Pygene.  I feath and the file Medical Exercities must be notified at other traumatic event. In Medical Exercities must be notified at		19a. Informant's Name/Relationship (Type William Quandt/sp	oe, Print) 1: OUSE	9b. Mailing A 404 M	ddress (Street :	and Number or Rural L1 Lane, A	Route Number, ot B Sa	City or Town, State, A	Zip Code) ID 21801
Deficiency Ministers of the permit. Pages 1 and 2 Department of Health s Important: if item 27 is any injury or other tra		20a. Method of Disposition		of Dispositio	100			Oc. Location - City or	
ages ant of it: # it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ② Donation 5 ☐ Other (Specify)	emoval from State Anal	tery, cremato COMY G	ifts	10/2	-		
nit. Partme		21. Signature of Funeral Service Liven	Reg:	istry 22 r Na	menand Addres			Hanover,	
Depa Depa Impo any ir		16ste R Mon	un CETS	50	1 Snow	Hill Rd.,	Salisbu	ry, MD 21	Association 804
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Circhaeis a	f t	he ,	Live			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence						
LAdminer	_	Sequentially list conditions, b	Bush (constant)	- 40					
ted nsit	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ory.					
te be executed ysician and e burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequenc	e of):					
- W - C 0	cai	۵							
The law requires that the death certificate b tee has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Medi	IC CENALE.							
th ce tendii	an/	230. Was decedent pregnant	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ith 3□Ecto	opic pregnancy			23d. Date of del	
t the dea by the al	slcl	in the past 12/months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of death 9☐ Unknown		ner (specify)			Month	Day Year
that the ed by detac		Part II. Other significant conditions con	tributing to death but not resulting	in the under	ving cause give	on in Part I	23a Did toba	cco use contribute to	the cause of death?
uires d be	d by			,	,,g 02200 g.v.	AT Cart 1.	1 🗆 Yes	$\times$	obably 4 Unknown
w requir been s should	Completed						24a. Was an	24h Word av	topsy findings available
The lavate has	mo						autopsy perferme	prior to death?	completion of cause of
	0	25. Was case referred to medical				26. Place of Death		No 1 □ Yes	2/CTN0
<b>.</b>	To B	examiner?	ospital: 1 Impatient 2 ERV	Outpatient 3	DOA Othe	_		ce 6 □Other (Spec	cify)
ng Ph kter th		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of Injury	28c. Injury Work	at 28	d. Describe how		
Attending ir death. ector: Aftei by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No			
or A after of Direction by	ertification	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, f	factory, office	28	If. Location (Stre City or Town, .	et and Number or Ru State)	ral Route Number,
Hospital	O	29a. Certifier Certifying Phys	cian: To the best of my knowled	ge, death occ	curred at the time	e, date and place, ar	d due to the cau	sa(s) and manner as	stated
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investig	gation, in my op	inion, death occurred	at the time, date	and place, and due	to the cause(s)
Vithir To the Comp	×	29b. Signature and title of certifier	100		29c. License	number	290	. Date signed (Month	n, Day, Year)
20		0000	W MI	7	00	16278		9-29.	-06
182		30. Name and address of person who cor	40 1111	(Type, Print	Ox I	201/75	) ()	//	0 1 6 0 7 =
Sta	0	31. Date filed (Month, Day, Year)	32. Registrar's Signature	spie	10/	Sox [733	) Vel	WY) MI	21802
Registr:		DCT 0 3 20	ne Z	1	~6				

		Registrar				CEI	lilicate of	Deal	11		Reg. No.			
Dhusiai		1. Decedent's Name	e (First, Middle, Las	st)						2. Date of D Month	eath Day	Year	3. Time	of Death
Physicia /Medic		Clare	Marie Ro	mnosky							2, 20		4:50A	M M
Examin		4a. Facility Name (/	f not institution, give	e street and number)			4b. City, Town,	or Locatio	n of Death		4c. Cou	nty of Death	1	
	435	Washir	ıgton Adv	entist Hos	pital		Takoma				Montg	omery		
Funeral		5. Social Security N	1	ex 7. Age □M 2XIF	e (In yrs. last t		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of B (Month, D	irth lay, Year)	9. Birth	nplace (State untry)	or Foreign
Director	ļ	577-42-35	520	UM 201F	73	Yrs.	1			May 9		PA		
pu »	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wm or Lo	cation						10d, Inside (	City Limits
anyla eho	-	Toa. State			Too. Oity, To	, WIT OF EO	Dation							s 2 🗓 No
Sa-f	ecto	MD	Prince G	eorge's	Hyatt	svil								
vith ti	E L	10e. Street and Nur		- 4			10f. Zip Code				10g. Citizen		untry?	
ath v	E .		nnon Stre			1.00	2078		0::0/0	7.37	USA	Race - Amer	for ladica	
er de Item	Funeral Director	11. Marital Status	ied 2 Married	12. Was Decedent 8 Armed Forces?		13. 4	Vas Decedent of Yes, specify Cut	ban, Mexic	can, Puerto	Rican, etc.)	0- I4. F	Black, White		
filed within 72 hours after death with the Maryland Hygiene. sither then "naturel", or Iteme 23a or 28a-f ehow ent, the Medical Examiner must be notified at	by F	3 Widowed		1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	40	1	☐ Yes 2X No	Speci	ty:		Spe	cify: Wh:	ite	
n 72 hours "naturel", edical Exa			15. Decedent's Ed		16	Sa. Deced	ent's Usual Occu	pation			16b. Kind o			-
in 72 n" na faction	Completed		cify only highest gra	de completed)		(Give	kind of work done  OO NOT use retire	during m	ost of work	ing				
with iene.	mo	Elementary/Seco		College (1-4or 5		Pavro	oll Cler	·k				ict of ernmer	f Colu	mbia
Hilad Hyg other	BeC	17. Father's Name	(First, Middle, Last)			- 0.7 -	0101		ther's Name	e (First, Middle	e, Maiden Sun			
d be ental ked c	To B	Joh	nn J. McN	abb					Ann V	. Toron	nich			
should Ind Men	-	19a. Informant's Na	ame/Relationship	Type, Print)	15	9b. Mailin	g Address (Stree	et and Num	ber or Rura	al Route Numi	per, City or Tox	wn, State, Z	ip Code)	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natur any Injury or other traumalic event, the Medical ORDS.		John	E. Romno	sky /Husba	nd 2	409 1	Hannon S	tree	t. Hva	attsvil	le. MD	20781	3	
Hea Hea tem	100	20a. Method of Disj		, , , , ,	20b. Place	of Dispos	sition (Name of			Date	20c. Locatio			
Pages nent of I ant: If It		4.4	_	Removal from State	1	-	natory or other pla Heaven C		Oct	6 200	6 911	TOT ST	orina	MD
it. Pa			5 ☐ Other (Specify Ineral Service Licer		Jace		. Name and Addr			0, 200	0 511	ver s	er rug,	FID
Deparenti Deparenti Importanti eny Ir	0	21. Signature or Fu	Tieral Service Licer	1300			ancis J.			Tuneral	Home,	Inc.		
	- 1	Jan		and .	I the death D	500	O Univer	sity	Blvd.	. W Si	lver S	pring,	MD 2 Approxima	
				plications that caused one cause on each lin	ne.	O HOL BILL							Interval Be	etween
Physician	3 19	Immediate Cause disease or condition		a Meto	stat	ìC	cancu	1	> liv	er, u	nknow	n Runy	un 9/	7/01
/Medical Examiner		resulting in death)		Due to (or as	a consequenc	e of):	1			,				
LAdillillei	_	Sequentially list co	nditions,	b. 50011	16.5	na	K						7114	106
pa tis	Examine	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	imediate rilying	Due to (or as	a consequenc		. 0 0 .	- 1					alu	10
and tran	саш	that initiated events resulting in death)		c. Cittle	a consequenc		al fa	1111	100				ulle	Uç
		,		A C (1 C	a consequenc	11 +	10 .						ali	100
h certificale be executed ending physician and r use as the burial-transit	an/Medicai		•	d. COCKY	my		range of						4/16	100
ling p	Me	IF FEMALE:		20: #			7							
ath co	an/	23b. Was deceden in the past 12		23c. If yes, outcome 1 Live birth	2 Fetal dea	ith 3	Ectopic pregnanc	су			1	Date of deline Month	very Day	Year
Attending Physician: The law requires that the deat ir death. •ctor: After this certificete has been signed by the ette by the funeral director, page 2 should be detached for	Physici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4☐Pregnant at 9☐ Unknown	time of death	5 🗆	Other (specify) _						54)	1 041
d by detach	Ph									00 5:4				1
es the	þ	Part II. Other signii	icant conditions c	ontributing to death bu	ut not resulting	g in the ur	nderlying cause g	iven in Pa	rt J.		tobacco use c			_/
equil sen s ould	ted					-				1 🗆	Yes 2 □ No	3 □ Pro	bably 4 🗷	Unknown
law r as be 2 sh	Completed									24a. Was	s an 24	b. Were aut	opsy finding	s available
The ate h	E									perf 1 ☐ Yes	ormed?	death? 1 ☐ Yes	2 🗆 No	00050 0.
tor, p	e e	25. Was case refer	red to medical					26. Pla	ace of Death	(Check only				
ysici is ce direc	O B	examiner? 1 ☐ Yes 2 Ø	No	Hospital: 1 Inpatie	ent 2 ER/C	Outpatien	t 3 DOA O				idence 6 🗆	Other (Spec	ify)	
g Ph er th eral	L L	27. Manner of Deat		28a. Date of Injur (Month, Day		. Time of	28c. Inju	iry at			how injury occ			
ndin ath. r: Aft e fun	윺	1 ☑Natural 2 ☐ Accident	5 Pending investigation		y rear)	Injury		Yes 2	□No					
Atte	<u>≓</u>	3 🗋 Suicide 4 🔲 Homicide	6 Could not be determined	286. Place of Inju	ury - At home,	farm, stre	et, factory, office	)			(Street and Nu	mber or Ru	ral Route Nu	mber,
alor s afte	Certification:	4 [] Nothicide		building, etc	c. (Specify)					City of 10	own, State)			
nours inera y fille	alc	29a. Certifier	1 ☐ Certifying Ph	ysician: To the best of	of my knowled	ige, death	occurred at the t	time, date	and place,	and due to the	cause(s) and	manner as	stated.	
P Ho	Medical	(Check only one)	2 Medical Exam	niner: On the basis of and manner sta	examination a sted.	and/or inv	restigation, in my	opinion, d	eath occurr	ed at the time	, date and place	e, and due	to the cause	(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ž	29b. Signature and	title of certifier				29c. Licen	se numbe	or .		29d. Date sig	ned (Month	, Day, Year)	
		Mak	thei	1			06	450	01		10/	2/0	(0	
4		30. Name and addr	ess of person who	completed cause of de	eath (Item 23a	a) (Type. I	Print)		-		, 10	, 0	7	
/			an Vu Mai				e. Takon	na Pa	rk. M	D				
Sta	te	31. Date filed (Mon		32. Pegistra	ar's Signature		1 185		,					
Registra			<b>3CT</b> 0 3 2	1006   Magazi	w H	Do	gent o							

			2.0				artment of				ene .		
			1 - State Registrar		,	•	rtificate of				<u> 2</u> 0(	16	32946
e of	Physici	an	1. Decedent's Name (First, Middle	Last)					2. Date Mon	of Death	Day	Year	3. Time of Death
	/Medic	al	Bahram	<del></del>		bzadeh	T 0: -			ember	28,		12:58 p.m
•	Examin	er	4a. Facility Name (If not institution, 6200 Westcheste			#121Q	4b. City, Town,		or Death		4c. County		orge's
	Funeral	state fr.		6. Sex	7. Age (In y	rs. last birthday		If Under 2	24 Hrs. 8. Date Min. (Mor	of Birth			place (State or Foreign
¥	Director		100-52-2695 Usuel Residence of Decedent	1 <b>X</b> □ M 2□	57	Yrs.	Month's Days	Hours		28,		Irar	
	ryland how		10a. State 10b. County		10c.	City, Town or L	ocation					1	0d. Inside City Limits
	Ba-f e	Director	Maryland Prince	George	's C	ollege							1 ☐ Yes 2X No
	with the or 2	Dir	10e. Street and Number	D1.	D	#1010	10f. Zip Code	`			. Citizen of		
	death ms 23	Funeral	6200 Westcheste 11. Marital Status	12. Was E	Decedent Ever in		20740 Was Decedent of If Yes, specify Cut		gin? (Specify Yes			ce - Americ	can Indian,
9	or ite	/ Fui	1 ☐ Never Married 2 🔀 Marri		IForces? es 27∏ No , Give	:	1 ☐ Yes 2 ☑ No		, Риепо Нюап, е	tc.)		ck, White, y: Asi	
Ş	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow the Medical Exacting must be notified at	Completed by	3 Widowed 4 Divorced	Year	or Dates:	16a Door	edent's Usual Occu			16	b. Kind of B		
5	n 72	plet	(Specify only highes Elementary/Secondary (0-12)	grade complete	ed) je (1-4or 5+)	(Giv	e kind of work done DO NOT use retire	during most	of working	10	O. Kald OI B	102111922/111	dustry
212	ge with	Com	12		19 (1-401 5+)	Cab	Driver	.,		W	lor1d	СаЪ	
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, L	,					r's Name (First, I			me)	
2	hould id Mer mark matic	ဥ	Abus Rajabzadeh  19a. Informant's Name/Relationsh			19b Mail	ing Address (Stree	Anice		Sal		State Zin	(Code)
	nd 2 s alth an 27 ie r trau		Leila Rajabzade		ghter								ark, MD2074
Baltimore,	of Head		20a. Method of Disposition 1   Burial 2 □ Cremation		208	o. Place of Disp	osition (Name of	1	Date		c. Location		
Ĕ	Pagiment tant: i jury o		4 □Donation 5 □Other (Sp		Ma Ma	aryland Memoria	matory or other pla National Park	09	9/30/200	6 La	urel,	Mary	land
Bal	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23s or 28s-1 show eny injury or other traumatic event, tra Medical Exacting must be notified at one.		21. Signature of Funera	nsee	MOO		2. Name and Addr Thibadeau 933 Gist	Morti	lary Ser	vice, er Sp	P.A.	MD 2	0910
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications th	at caused the do								Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		chogeni		noma						Onset and Death 2 years
	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due	to (or as a cons	sequence of):							
		ner	Sequentially list conditions, it any, reading to infiltration cause. Enter Underlying Cause (Disease or injury	b. Sue	to (unas a cons	requanca of):							
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
,60	be exician dician burial	cal E	, and a second second		to (or as a cons	sequence or):							
687	ificate g phys as the			d.			=====		711 PERF				
30X	ith cert itendin	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of pre-		□Ectopic pregnanc	¢y.			1	ite of delive	ery Day Year
.O. Box	that the death certificat led by the attending phy detached for use as th	Physician/Med	1 Yes 2 No		egnant at time onknown	oldeath 5	Other (specify)					J. (1)	Day 16a1
S, D	res that igned b	by PI	Part II. Other significant condition							. Did toba	cco use con	tribute to th	ne cause of death?
ord	w require been sig should t		Thallassemia Ma	jor, He	mosider	osis, C	hronic Ob	struct	tive	1 🔼 Yes	2 🗆 No	3 Prob	ably 4 Unknown
Records,	e la has	Completed	Pulmonary Disea	se, Dia	betis M	ellitus	, Gallsto	one		. Was an autopsy performe	24b.	Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Death Check	707	J NO	T L Tes	2 140
	Physic this ce al dire	P	1 ☐ Yes 2X No			ER/Outpatie	all ou box		rsing Home 5 🖔				r)
Division of	Attending Physician: r death. sctor: After this certificing the funeral director.	tion:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investig		ate ol Injury fonth, Day Year	28b. Time ( Injury	Wo	ıryat ork? ]Yes 2 ∐ N		scribe how	injury occur	red	
VISI		Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Pl	ace of Injury - A	t home, larm, s	treet, factory, office		281. Loca	ation (Stree	et and Numi	ber or Rura	I Route Number,
	o # 5 ⊆				uilding, etc. (Spe					or Town, S			
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in	Medical	29a. Certifier 1 🔀 Certifying (Check only 2 Medical E	xaminer: On th	the best of my l e basis of exam nanner stated.	knowledge, dea ination and/or i	th occurred at the to nvestigation, in my	ime, date and opinion, deat	d place, and due h occurred at the	to the caus time, date	se(s) and mage and place,	anner as s and due to	tated. the cause(s)
	To the Vithin 2 To the Complet	Σ	29b. Signatule and title of certifier	00			29c. Licen	se number		29d	. Date signe	d (Month,	Day, Year)
)	1-		- U Wamer	2.1	47 1	^,	D296	71		S	epteml	ber 2	9, 2006
	(A)		30. Name and address of person v				Rd., Che	werlv	_ MTD 20	785			
3	Sta		31. Date filed (Month, Day, Year)	2'	Dagietrar'e Si	gnaturo		JULLY	, 20				
100	Registr	ar	OCT 0 3	2006	Togistial's Significant	N B	CONEL!						

DHMH 17 Rev 1/2001

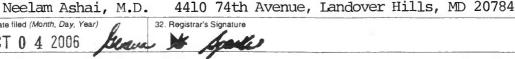
ORIGINAL

			1 - State of Maryl State of Maryl	and / Depa <i>Ce</i> a	artment rtificate	of Hea	ilth and l eath	Mental Hy	giene 0	06	32947
	Physici /Medi		Decedent's Name (First, Middle, Last)     CALVIN LEE RICHMOND					2. Date of De Month SEPTEM	BER 28,	Year 2006	3. Time of Death 1:00A M
	Examir		4a. Facility Name (If not institution, give street and number) HEARTLAND HEALTHCARE		4b. City, To	ADELI	eation of Deati	h		ty of Death	CORGES
	Funeral Director		XXIM 2 TE	yrs. last birthday) 50 Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.	(Month, Da	th ay, Year) 9, 1945	Coul	place (State or Foreign http:// HINGTON, DC
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or iteme 23s or 28e-f show any injury or other treumatic event, ir a Marical Exemitian manual pance.	Funeral Director	10a. State 10b. County 10c.	City, Town or Lo		ode 207	721		10g. Citizen of		
9600	nours efter death urei', or tteme 23	ğ	11. Marital Status  1 Never Married XXMarried  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1XX'es 2 2 No If Yes, Give Year or Dates: 196	1	Was Deceder If Yes, specify	nt of Hispar Cuban, M		pecify Yes or No o Rican, etc.)	14. Ra Bl	ace - Americack, White,	ean Indian, etc.
d 21215-0036	filed within 72 h Hygiene other than "natu	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  1+  17. Father's Name (First, Middle, Last)	(Give	DO NOT use	done durin retired) L FIF	g most of wor REFIGHT		DC GOV	'ERNME	,
Maryland	should be id Mental marked o matic eve	To Be	ISAAC RICHMOND  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	a Address (6	N	IAXINE	CHEEKS		·	Codel
Baltimore, Ma	s 1 and 2 s f Health ar Item 27 is other treu		SHAWN P. RICHMOND / WIFE 20a. Method of Disposition 201		GOLF C	OURSE		MITCHEL Date		MD 2	0721
altimo	mit. Page: partment o portent: if / injury or		XXBurial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	VETERA	NS CEM	ETERY		4/2006 AL HOME	CHELT		
ä	perm Depa impo any ii	7	23a. Part Etter the disease, or complications that caused the d shock of heart failure. List only one cause on each line.		4308	SUITL	AND RO	DAD SUI	TLAND,	MD 20	746
8760,	Physician and // Medical Examiner step private the private transit step	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the cause) of the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the cause) of the cause of the c	Sequence of):  N Sequence of).	ARREST						Interval Between Onset and Death
.O. Box 6	death certine attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preduction in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 [	Ectopic preg Other (spec					ate of delive	ery Day Year
rds, P	6 60	by	Part II. Other significant conditions contributing to death but not CEREBRO VASCULAR BLEEDING	resulting in the ur	nderlying cau	se given in	Part I.				ne cause of death? ably XX Unknown
al Record	The ete h page	e Completed	METASTATIC BRAIN TUMOR  25. Was case referred to medical					1 Tes	rmed?	Were autopprior to condeath?	psy findings available inpletion of cause of
Division of Vital	Phys this ral dii	Certification; To Be	examiner?  1	28b. Time of			Nursing H	th <i>Check onl</i> o	dence 6 🗆 Oti		<i>'</i> )
DIX	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe	ecify)				City or Tow	vn, State)		l Route Number,
	To the Hospitei within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier (Check only one)  Medical Examiner: On the basis of exam and manner stated.  29b. Signature and title of certifier	nowledge, death ination and/or inv	estigation, in	my opinior	n, death occur	red at the time,	date and place,	and due to	the cause(s)
	£ ₹ £ 8	-				05614			29d. Date signe		
	61		30. Name and address of person who completed cause of death (I NASREEN KANGO, M.D.	7610		L AVE	NUE #2	05 TAK	OMA PAR	K, MD	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 4 2006  32. Registrar's Signary	pature							

			For State Registrar	State of Ma	-		rtment of H ificate of L		and M		giene Reg. No.	06	32948
Ц	Physici	an	1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		ELIZABETH	М.	STRAZZI					SEPT 2	28	2006	7:40 P M
ž	Examin	er	4a. Facility Name (If not institution, giv LAURELWOOD NURSI				4b. City, Town, or ELKTON	Location o	of Death			onty of Death	1
	Funeval		5. Social Security Number 6. S		(In yrs. last birt	hday)	If Under 1 Year	If Under		8. Date of Birt	h		nplace (State or Foreign
Ш	Funeral Director		222 09 3469	1□M 2 <b>X</b> )F	87	Yrs.	Months Days	Hours	Min.	(Month, Day MAR 24			WARE
-	pu * III		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orloc	ation		···-				10d. Inside City Limits
	/anyla	ō		т.	,								1 <b>X</b> Yes 2□No
	28a-	Director	MD CECI  10e. Street and Number	T-	El	LKTO	10f. Zip Code				10g. Citizen	of What Cou	untry?
	h with		100 LAUREL DRIV	E			21921				U.S.	Α.	
	dear dear	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	spanic Ori	gin? (Spe	city Yes or No- Rican, etc.)		Race - Amer Black, White	
36	s 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehow other traumatic event, the Madical Examinational be notified at	by Fu	1 Never Married 2 Married  3XXWidowed 4 Divorced	1 ☐ Yes 2 <b>X</b> If Yes, Give Year or Dates:	io	11	☐ Yes ※XXNo	Specify:				ocifyWHIT	
21215-0036	thour	ed t	15. Decedent's E		16a.		int's Usual Occupa				16b. Kind o	of Business/li	ndustry
212	hin 72 9. Marii	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  Cottege (1-4or 5	+)	(Give k.	ind of work done of O NOT use retired	during mosi I)	t of workir	ng			
2	filed wit Hygiene other the	Con	12			НО	MEMAKER					HOME	
ng	be file	Be	17. Father's Name (First, Middle, Last	)						(First, Middle,	Maiden Sur	name)	
Maryland	2 should be and Mental le marked c	2	JAMES MAHONEY  19a. Informant's Name/Relationship (	Tune Print)	19h	Mailing	Address (Street a			POTTS	or City or To	un State 7	in Code)
2	Ith an		FRANCIS STRAZZEL			110	RVIN COU						
ā,	s 1 end 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place of	Disposi				ate		on - City or T	
altimore,	Pages nent of I int: if its iry or o		1 X Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Specia		- I		CEMETER	<sub>Ψ</sub> ¦0	CT 3	,	WILMI	NGTON -	DE.
<u>a</u>	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Lice	nsee		22.	Name and Addres	s of Facilit	У				
<u> </u>	80599		107m	upper	M-00784							366, W	ILMINGTON DE 19805
No.	Physician /Medical Examiner		23a. Pan1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	aS	ARCOM a consequence of	A	LEF7			e Ext		>	Approximate tintervat Between Onset and Death
*	LXaiiiilei	Je	Sequentially list conditions,	b. Due to for as	a consequence o	eff:		-					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events			,							
o,	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence o	of):							
8760,	ate be	dlcal		d									
O. Box 6	The law requires thet the death certific tie has been signed by the ettending p page 2 should be detached for use as	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d.	Date of deliving Month	very Day Year
₽.	s thet t ned by e detac	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in	the und	derlying cause give	en in Part I.		23e. Did to	obacco use o	contribute to	the cause of death?
rds	w requires been sig should be									101	res 2□N	o 3 🗆 Pro	bably 4 Unknown
Division of Vital Records,		Completed								24a. Was autop perfo 1 Yes		b. Were aut prior to co death? 1 \( \text{Yes}	topsy findings available ompletion of cause of
/ita	ician: Sertific Sector.	Be	25. Was case referred to medical examiner?	Hamita			100		of Death	Check only o	ne		
<del>6</del>	Physical direction	2	1 Yes 2 No  27. Manner of Death	Hospital: 1 tnpatie		_	3□ DOA Othe	NU		ne 5 Resid			ify)
o	tending Physician: The leath. tor: After this certificate hithe funeral director, page	tion	1 Naturat 5 Pending 2 Accident investigation	(Month, Day		njury	Work	k? Yes 2 🔲 I		.00. 00301061	iow injury oc	curred	
IVIS	i or Attending Physician: effer death. Director: Affer this certifica I in by the funeral director. I	Certification:	3 Suicide 6 Could not be determined	OB Diago of tais	ury - At home, far c. (Specify)	rm, stree	et, factory, office		2	28f. Location (S City or Tox	Street and No vn, State)	umber or Rui	ral Route Number,
	spitai		29a. Certifier 1 Certifying/P	hysician: Yo the best	of my knowledge	, death	occurred at the tim	ne. date an	d place, a	and due to the	cause(s) and	manner as	stated.
	To the Hospital or At within 24 hours effer of To the Funarel Dirac completely filled in by	edical		miner: On the basis of and manner sta	examination and								
	To the To the Comp	M	29b. Signature and title of certifier				29c. License		_		29d. Date sig	gned (Month	, Day, Year)
			· /				DS	407	3		030	C7 0	6
	3		Vale	ONE, M	81	-	rint) (FURCHM)	ر ا	CM	N	en a	STLE	DE 1972
	Sta Registr		31. Date filed (Month, Day, Year) 1 OCT 0 4 200		ar's Signature	parl	e e						

within 2

31. Date filed (Month, Day, Year) State Registrar 0 4 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D48213

October 3, 2006

						artment of Health and	•	-	
			1 = For State Registrar			rtificate of Death		a. n2 0 0 6	32950
ı	Physici	an	Decedent's Name (First, Middle, La     JOHN ALBERT		SR.		2. Date of Death Month	R 10 200	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, giv		DI.	4b. City, Town, or Location of Deat		4c. County of Dea	
	Examir	ier	700 Port St.	o street and nameon,		Easton		Talbot	111
	Funeral			HERM OF LE	In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day,	Year) 9. Bir	thplace (State or Foreign buntry)
	Director		214-16-5208 Usual Residence of Decedent		81 Yrs.		Oct 22	1924   Mai	ryland
	rryland thow	_	10a. State 10b. County	16	Oc. City, Town or Lo	cation			10d. Inside City Limits
	the Ma	ecto	MD Talbo	t	Easton	1 m = 0			1 √Yes 2 No
	3e or	Funeral Director	700 Port St.			10f. Zip Code 21601		lg. Citizen of What Co $U ullet S ullet A ullet$	ountry?
	eme 2	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer		14. Race - Ame Black, Whit	
36	s afte	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give	1943	1 ☐ Yes 2½ No Specify:			hite
21215-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. d other then "natural", or Iteme 23e or 28e-1 show evant, Ita McJic. Exertifier that the nuillied at	ted k	15. Decedent's E	ducation	-1945   16a. Deced	dent's Usual Occupation	1	6b. Kind of Business	
218	ithin 7 ne. nen "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during most of wo DO NOT use retired)			
	filed w Hygiel ther ti	CO	17. Father's Name (First, Middle, Last	1	Sys	stems Analyst	me (First, Middle, M		g Services
<u>a</u>	nid be fental rked o	To Be	Daniel J. Scha				Sandku		
Maryland	2 should have and have list managed	-	19a. Informant's Name/Relationship (	Type, Print)		ng Address (Street and Number or Ru	ural Route Number,	City or Town, State, 2	
	1 and Health em 27 thar tr		Mary Jo Papin  20a. Method of Disposition	(daughte	er) 511 20b. Place of Dispo	2 North Dr. (	-	e, MD. 2	
TOT.	Pages ent of ht: If it		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, cren	natory or other place) 7's Cemetery 1	100		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28a-1 show minportant: If item 27 is marked other then "natural", or iteme 23e or 28a-1 show any injury or other traumatic evant, it is Medical Examiliar as any injury or other traumatic evant, it is Medical Examiliar as any injury or other traumatic evant, it is Medical Examiliar as any injury or other traumatic evant, it is Medical Examiliar as any injury or other traumatic evant, it is Medical Examiliar as any injury or other traumatic evant.		21. Signature of unitral Service Licer		_	Name and Address of Facility			
<u> </u>	89 5 2		1700		00510 1.	18 West Cross	St. Gale	ena, MD.	21635
			23a. Part1. Enter the disease, or com shock, or beart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	V220			st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Severe	onsequence of):	us Emphysem	_		154 cas
	Examiner		Sequentially list conditions.	b. Polmma		rosis			
M	bed sit	ninet	Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onlie wence of).				
og Judo	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):				
~	ate be hysicia the bur	licat		_ d					
x 68	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of p	pregnancy			1	
Box	death a atten d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	very Day Year
P.O.	at the	hys	9 🗆 Unknown	9□ Unknown					
ds,	ires th signed d be de	ρλ	Part II. Other significant conditions of Renal 1250 His		ot resulting in the ur	nderlying cause given in Part I.		icco use contribute to : 2 □ No 3 Pr	
Records,	w requ	ietec	1-000 1430411	101-1			24a. Was an		topsy findings available
Re	The la te has	Completed					autopsy performi	prior to death?	completion of cause of
Division of Vital	clan: ertifica actor, p	BeC	25. Was case referred to medical examiner?				th (Check only one,		2 No
of	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	Other: 4 Nursing H	lome 5 Residen		cify)
lon	nding ath. r: Afte e fune	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	Work? M 1 ☐ Yes 2 ☐ No	20d. Oescribe now	injury occurred	
Ν	r Atta ter dea irecto ir by th	Certification;	3 Suicide 6 Could not be determined		- At home, farm, stre Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	pital o		29a. Certifier 1 Certifying Ph	symiology To the best of a					
	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Exam	nysician: 10 the basis of miner: On the basis of exa and manner stated	amination and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as e and place, and due	stated, to the cause(s)
	Vithir To th comp	M	29b. Signature and title of certifier	1 40		29c. License number	[	d. Date signed (Month	
		Ti	> alla Vel			D0040274		10/11/2000	
	My,		30. Name and address of person who Allen Webb, M.			e Dr. Easton,	MD. 216	01	
	Sta		31. Date filed (Month, Day, Year)	1000 00					
	Registra	ar	OCT 1 7 200	10	AS PERMA	P. C. C. C. C. C. C. C. C. C. C. C. C. C.			

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of He	ealth and Me Death	ental Hygier Reg. P	2006	32951
			Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physici /Medio		CALVIN CLA	RENCE ST	EWART,	JR.		OCTOBER	11 2006	2:00a M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		c. County of Death	3
			32960 Galena			Galena			Kent	
	Funeral Director		218-24-4744	5. Sex 7. Ag 1122 M 2□F	e (In yrs. last birthday) 75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Jov 9 19	Cour	place (State or Foreign htry) yland
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Mary i-f sh	tor	MD Kent		Galena					1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cour	ntry?
	th wit		32960 Galena	Sassafras	Rd.	21635		U.	S.A.	
21215-0036	be tiled within 72 hours after death with the Maryland ital Hygiene. od othar than "natural", or items 23a or 28a-f show avant, the Medical Eraminer must be trollified at	by Funeral	11. Marital Status  1 Never Married \$\int\text{Divorced}\$ Married 3 \( \text{Widowed} \) 4 \( \text{Divorced} \)	12. Was Decedent Armed Forces? d 1 Yes 2 1 FYes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spec i, Mexican, Puerto R Specify:	ify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Wh	
9-19	2 ho	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	tion	16b.	Kind of Business/Inc	dustry
215	within 7 ene. than "n	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	ife.	kind of work done di DO NOT use retired)	iring most of working	C	hemical	
7	filed with Hygiene Ithar than	Соп		2		sign Eng	ineer	M	anufactu	ırer
Ind	be fill d oth avan	Be	17. Father's Name (First, Middle, La				18. Mother's Name (		en Sumame)	
yla	should be nd Mental marked o	To	Calvin Clare				Sylvia T	*		
Maryland	nd 2 shoulth and 27 is mur	r N	19a. Informant's Name/Relationshi Nancy Stewar			ng Address <i>(Street ai</i> 50 Galena				
	1 al Hea		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	Da		Location - City or To	
ë E			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Shrewsh	matory or other place oury Ceme	etery 10	/14/06	Kennedyv	ville, MD
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signatura of Fun ral Servi > Li		$M \cap G \cap G \cap G$	2. Name and Address alena Fu 18 West (	neral Ho	me of S	tephen I	Schaech
	- 1		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused	the death. Do not ent	ter the mode of dying	, such as cardiac or	respiratory arrest,	a , MD • 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		10SCLBRE	TIC CA	POINCAC	11140	MICKALL	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	, , , , ,	VIUVAEC	9417	MERRE	
	Examiner		Sequentially list conditions,		DONARY	FIBR	2120			
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
13	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68760,	ficate be executed physician and is the burial-transit		A	d						
	g phy as the	ledicat		0.						
P.O. Box	law requires that the death certilic as been signed by the attending p 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
	res that i	by Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
rds	w requires been sign should be						· · · · · · · · · · · · · · · · · · ·	1 🗆 Yes	2 □ No 3 □ Prob	ably 4 🗩 Unknown
Vital Records,	The ate his page	Completed						24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death (			
of/	Physic this c al dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie			4   Nursing Home		6 ☐ Other (Specify	)
on c	ng ftei ine	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year) 28b. Time o	Work?		3d. Describe how inj	ury occurred	
isi	Attanding r death. actor: After by the funer	licat	2 Accident investigat 3 Suicide 6 Could no	t be gen Bloom of Inju	ury - At home, farm, str		9S 2 No	Rf Location (Street	and Number or Rura	I Pouto Number
Division	after after Dira	Certification:	4 ☐ Homicide determin	building, etc	(Specify)	eet, ractory, onice		City or Town, Sta		noble repliner,
	To the Hospital or Attanding Is within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	examination and/or in	h occurred at the time vestigation, in my opi	, date and place, an nion, death occurred	d due to the cause( d at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	To th within To thi compl	Me	29b. Signature and title of certifier			29c. License	number	29d. D	ate signed (Month, I	Day, Year)
			Kurkey	e Mo		2000	7509	1	0/11/06	
	1401		30. Name and address of person with SAMES LACEY.	Mo 216	eath (Item 23a) (Type,					
	Sta Registra		31. Date filed (Month, Day, Year)	7 2006 32. Registra	eath (Item 23a) (Type,  RAILRURY  ar's Signature	frost.				

06-07371 Loniel Smith

# Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of	Death		Re	g. No. 20	106 3295
Physician Medical Examine		:	2. Date of Death  Month Day Year October 1 2006  3. Time of Death 0045 hrs				
gant.	4a. Facility Name (if not institution, give street and number)	41	o. City, Town, or Lo	ocation of Death	October 1,	4c. County of	
	Prince Georges Hospital Center		Cheverly			Prince G	eorge's
Funeral Director		n yrs. last birthday)	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.		h(MM/DD/YYYY) 1988	Birthplace (State or Foreign WASHINGTO)     Country)
Director	219-35-5788 1 XM 2 F 18  Usual Residence of Decedent	Yrs.			JANUA	RY 1388	Country) DC
any	10a. State 10b. County 10c	c. City, Town or Locatio	n T				10d. Inside City Limits
vlaryland 28a-f show any 1 at once.	MD PRINCE GEORGE'S	RIVERDAL	,E				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and <b>N</b> umber		10f. Zip Code		10	g. Citizen of Wha	at Country?
0036 within 72 hours after death with the Maryland stone. ner than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once must be notified at once must be notified at once must be notified at once Demonstrate or Director	5606 SILK TREE DRIVE  11. Marital Status 12. Was Decedent Eve	er in II S 13 Was	20737 Decedent of Hispa	onio Origina / Sno	oifu Voc or No	U.S.A.	American Indian, Black,
r death with or items 23 must be no	1 X Never Married 2 Married Armed Forces? 1 Yes 2 Y	If Yes	s, specify Cuban, N			White,	
s after (ral", o	3 Vidowed 4 Divorced If Yes, Give Year or Dates:	1 1	Yes 2 X No	specify:		Specify:	BLACK
hin 72 hours after than "natural" edical Examine	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12) College (1-4 or 5+)		s Usual Occupation st of working life. D			16b Kind of Bus	iness/Industry
5-0036 ed within 72 hours tygiene. other than "naturithe Medical Exam	1 YR	STUDEN	IT			PRIVATE	
15-0 filed will Hygie od other			_	Mother's Name (	First, Middle, M	laiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than revent, the Medica		19h Mailing	Address (Street a	VICTORIA	A SMIT	H	0 7.0.1
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me To Be Com	VICTORIA SMITH-LLOYD/MOTHER	5606	SILK TREE	E DRIVE	RIVERDA	LE, MARYL	AND 20737
re, re, rand f. Healt f. Healt f. Fitem	20a Method of Disposition  1	20b. Place of Dispositi		tery,	Date	20c. Location - C	City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify:	FT. LINCO	LN CEMETE	ERY 10-	6-2006	BRENTWOO	D, MARYLAND
Balti permit. Departu Import	21. Signature of Funeral Service Licensee		me and Address of	´ J.	B. JEN	KINS FUN	TERAL HOME
Physician	23a. Part I. Enter the disease, or complications that caused the	death. Do not enter the	mode of dying, su	VER KOAD ich as cardiac or r	LANDO\ espiratory arre	VER, MARY	LAND 20785 t Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot V						Between Onset and Death
-xammer	or condition resulting in death)  Due to (or as a consequence)	ence of):					
1	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence)	ence of):					
led nsit	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)	ence of):		_			
ial ial	UNPENDED AMENDED						
S 1 S 2	IF FEMALE: 23b. Was decedent pregnant in the	of pregnancy 2 Feta	I death 3	Ectopic pregnanc	°V	23d. Date of de Month	elivery Day Year
Box 687  The death certification is a set of the astending proof of the set o	past 12 months?    1   Yes 2   No 9   Unknown   0   Unknow	a of dooth	er (Specify)	]   P = 3	,		ouy rou
by the by the defacted f	Part II. Other significant conditions contributing to death bu	it not resulting in the un-	derlying cause give	en in Part I	23e Did tob	pacco use contribu	ute to the cause of death?
ires that the signed by it be detached	'l	•	,				Probably 4 Unknown
of Vital Records, g Physician: The law require- ther this certificate has been signeral director, page 2 should be 1: To Be Completed			_		24a Was ar		ere autopsy findings available or to completion of cause of
tal Reco cian: The law certificate has ector, page 2 s					perform	ned? dea	ath?  Yes 2 No
Vital Recystican: The librate of director, page				Death (Check on	ly one)		
f Vit Physic er this ral dire	1 V Yes 2 No Inspired Impatient	2 ✓ ER/Outpatient  28b. Time of Inju					Other:
Division of Yspital or Attending Phrous after death.  neral Director: After trilled in by the funeral Certification: T	1 Natural 5 Pending FOUND: Day, Year)	FOUND:	. 1		ubject was	ow injury occurred shot	'
Division at or Attendir rs after death. at Director: A led in by the fu	2 Accident Investigation Oct 1, 2006 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, street,	factory, office build	ding, etc. 2			or Rural Route Number, City
Divis spital or At hours after d neral Direc filled in by	4 V Homicide determined (Specify) Local	Street		75	or Town, Sta 519 <b>Green l</b>	eaf Rd., Lan	dover, Md.
Division of Vital Records, P.O. Box 63  To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Physicia							
To To Con	29b. Signature and tribe of certifier		29c. License n				(Month, Day, Year)
(4)	I VM. 1/E		O.C.M.	E.		October 1, 2	
100	30 Name and address, person who complified cause of death	'	01: : 5 :::				
State	Jack Titus MD. Deputy Chief Medical Exan  31. Date filed (Month, Day Xear)  32. Registrar's S		Street, Baltim	nore, MD 212	U1 ————		
Registra		good					

			1 - For Amend Items 2	State of Maryland 5,27,28a-f pe	d/Depa	artment of 1	lealth and I 2/06dhb Death	Mental Hy	giene 0	06	32953
			1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath		3. Time of Death
	Physici /Medic		Clyde William SOUT	'H				OCTObe	Day 4	2006	2:25 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death			ty of Death	
فيز			Washington County				lagerstow			ashing	
	Funeral		5. Social Security Number 6. Sex	M 2□F	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	y, Year)		ace (State or Foreign try)
	Director		Usual Residence of Decedent	76	113.			Feb. 1	3 1930	Mar	yland
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Man	to	Maryland Washingt	on	Насе	rstown					1 X Yes 2 ☐ No
	deeth with the Maryland ms 23s or 28s-f ehow Frount be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
	1h wil	alD	913 Potomac Avenue			21	740			USA	
	r dee	nei	11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Ri	ace - America	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 No If Yes, Give		I ☐ Yes 2X No	Specify:		Spec		
5-0036	72 hours after natural', or Ite	q pe	3 Widowed 4 Divorced	Year or Dates:	16a Doore	tant's Havel Occur	nation		10h Kind of	Whi	
215	in 72 In Ins	Completed	(Specify only highest grade	completed)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most of world)	king	16b. Kind of	businessying	lustry
212	within piene. r than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales			Build	ing Su	nn1v
	othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,			PP/
lar	Ould by Menta Merked	To E	Hubert R. South				Fern 0	. Stotle	r		
Maryland	2 sho and h le ma	99	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Zip	Code)
	and 2 eelth n 27		Grace South - Wife				venue, Ha	agerstow	n, Md.	21740	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Items 23a or 28a-f ehow any folury or other traumatic event, the Medical Examination at any folure.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pl	ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	- City or To	wn, State
Ë	Peg ment lant:		4 ☐ Donation 5 ☐ Other (Specify)		se Hil	.1 Cemete	ry 10/	7/06	Hagers	town,	Maryland
3ail	Depertition of the portion of the po		21. Signature of Funeral Service License	0			ss of Facility M				
	005 • d		Tred how	estal			son Blvd.			Md. 2	
	Physician /Medical		23a. Pant1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  SUBDUCE  Due to (or as a consequence)	& :		ECM WOI	A		haye	Approximate Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions, b.	Directo (or as a consequ	anna offr		- /				417
	ate be executed whysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to humodiate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequ			CATION	1 Gul	AICAL EXAMINE	R	
8760,	be ey icien buria	E E		Due to (or as a consequ	ance or).		MONTE	APPROVED BY			
87	physis the		d.				CVIII.				
O. Box 6	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregntaring the past 12 mooths? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. D	ate of delive	ry Day Year
P.O.	thet the ded by		Part II. Other significant conditions cont	ributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of death?
sp.	uires sigr ld be	D D	Chroner hiv	e pusease	2	CORRI	hosis	1 🗆 Y	es 2 No	3 Proba	ably 4 DUnknown
Records,	w requir been s should	Completed by	DUTTED Mus	extension				24a. Was	an 24h	Were auton	sy findings available
Re	he lay e has	E C	5 1 - 5000	10100	150=	_ 12		autop perfo	rmed?	eath?	nptetion of cause of
	icien: Th certificete rector, pag	0	25. Was case referred to medical	Tucker 1)	yes	2	26. Place of Dea		2 10 No	1 ☐ Yes	2 □ No
>	ysicie s cert direct	To B	examiner?	ospital:	R/Outpatien	Oth	00	ome 5 Resid		ther (Specific	1
0	g Phys ter this neral di		27. Manne Ceath		28b. Time of Injury	28c. Injun		28d. Describe h			,
Ö	uttandin death. ctor: Afi y the fur	atio	2 Accident investigation	10/02/2004	ınknow	D 14	Yes 2∰No	Fall			
Division of Vital	or Attanding Physicien: ifter death. Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al hor building, etc. (Specify,	ne, farm, stre			28f. Location (S	itreet and Nuπ	ber or Rural	Route Number,
	Ital o			Home				913 Pot	omac Av	ле.,На М	gerstown,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	cai	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	rledge, death on and/or inv	occurred at the timestigation, in my o	ne, date and place, pinion, death occur	and due to the o	cause(s) and n	nanner as sta	ited.
	thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner stated.	1	29c. Licens			29d. Date sign		
	7. × 1.00	-	255. Orginators and title of certified	Children Co	50 /	250. 11	65 / Das	- /	Su. Date sign	ea (wonth, L	ay, rear)
•		-	Mospitale)	@ Wesh C	N14 /	COP M	000011	1	10/3	er 4	(2006
03	H-5		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, I	SI WIT	Antiet	2m 5	T Les	76015	Street MA
	Sta	te_	31 Date filed (Month Day Year)	32. Registrar's Signati		, ,	1,0,10,1	)	1 11	Jers	300
	Registr		OCT 0 5 20	JO Senew &	4. Do	well					

Joshua John Scharbor

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	Redistrar	Certificate of		na mentar		Reg No. 2	00	5 3295
Physiciar fledical Examin	1/	1. Decedent's Name (First, Middle,Last)  Joshua John Scharbor				2. Date of De Month		/ear	3. Time of Death 0003 hrs
N state		4a. Facility Name (if not institution, give street and number)		4b. City, Town,	or Location of D			ty of Death	
·		9028 Mountainberry Circle		Frederick			Freder		
Funeral Director		430-65-5961 <sub>1</sub> × <sub>M 2</sub> 5	rs last birthday) Yrs				1, 198	Torois	thplace (State or in Arkansas untry)
au's	ı		City, Town or Locati						10d. Inside City Limits
<u> </u>		Maryland Frederick I	Frederick						1 Yes 2 X No
the Na or	<u> </u>	10e. Street and Number 9028 Mountainberry Circle		10f. Zip Code 21702			10g Citizen of V	What Cour	ntry?
r death with or items 2.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes 2 New Yes Yes 2 New Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	If Ye	es, specify Cub	an, Mexican, Pu	( Specify Yes or N erto Rican, etc.)		hite, etc.	can Indian, Black,
rs after ural", miner	≥ -	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		Yes 2X 1	lo specify: pation (Give kind	of work done	Specify 16b. Kind of		hite
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			fe. DO NOT use		I SD. KING OF	3usiness/i	ndustry
5-0036 led within 7. Hygiene. other than	ᇍ	12	none				no	one	
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	3	17. Father's Name (First, Middle, Last)				ame (First, Middle,		ne)	
2121: hould be fi and Mental H is marked atic event,	<u> </u>	Gary John Scharbor  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Str		ie Yanosi or Rural Route Nu		own State	Zin Code)
MD 2 should be and MD 1 should be and MD 1 should be and MD 1 should be an armatic	-	Debbie Scharbor - mother							Maryland 21
S l an S l an S Hea If iten		1 Burial 2 Tr Cremation 3 Removal from State	Ob Place of Disposi crematory or oth rederick	ner place)	, ,	Date /30/06	Freder		Town, State Maryland
Baltimo permit Page Department of Important: injury or oth	t	21. Signature of Funeral Service Licenses	22. N	ame and Addre	ss of Facility	Stauffer	Funera	11 Ho	me
	4	Chamber Cene							ryland 2170
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	atri. Do not enter tr	le mode of dylf	g, such as cardi	ac or respiratory ar	rest, snock, or r	leart	Approximate Interval 8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	ce of):						Beaut
		Sequentially list conditions, b							
	<u>=</u>	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause C.	ce of);						
ed sit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	ce of):						
execution and and and and and		UNPENDED X AMENDED 4DTT 700							
760, Teate be executed sphysician and the burial - transit	Medical	#PII, per	rME, g860, 10	0/31/06 7	T		23d. Date	of delivery	
687 ertifica ding p	ani	3b. Was decedent pregnant in the past 12 months?	2 Fet	tal death	Ectopic pre	gnancy	Month	,	ay Year
Box 687 death certification at the attending of the as as the	ysician	1 Yes 2 No 9 Unknown 9 Unknown	or death 5 Oth	ner (Specify)			4:		
O. Bo at the de d by the stached f	5	Part II. Other significant conditions contributing to death but no	not resulting in the u	nderlying caus	e given in Part I	23e. Did t	obacco use cor	itribute to	the cause of death?
ires that to signed by a be detac	<u>8</u>	Paranoid schizophrenia				_ 1 Ye	s 2 🗸 No :	3 Prob	ably 4 Unknown
of Vital Records, ng Physician: The law require wher this certificate has been simeral director, page 2 should be a fire of the control of th	Completed					24a. Was auto			topsy findings available ompletion of cause of
Rec The la	ξĺ					perfo 1 ✓ Yes	ormed? 2 No	death? 1 ✔ Ye	s 2 No
tal Recian: The certificate ector, page	8 [	25 Was case referred to medical examiner? Hospital:   Input institute			ce of Death (Che				
Physical direction	앜	1 Yes 2 No Pospital 1 Inpatient 2  27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of Ir		Other Nu		Residence 6		Scene
on of nding Pl th r: After		1 Natural 5 Pending FOUND:	FOUND:	· ·   _	Yes 2 ✓ No	Subject har	nged self	irred	
Division tal nr Attendii rs after death al Director: A led in by the fu	<u> </u>	2 Accident Investigation Sep 25, 2006 3 Suicide 6 Could not be 28e. Place of Injury - A	2335 hrs At home, farm, stree					ber or Ru	ral Route Number, City
Division  Hospital nr Attenc 24 hours after death Funeral Director: stely filled in by the	Certification:	Suicide 6 Could not be determined (Specify) residence	ce			or Town, 9028 Moun	<sub>State)</sub> t <mark>ainberry C</mark> i	rcle, Fre	ederick, MD
	ह्र	29a. Certifier (Check only one)  2							
F 3 F 3	Ĭ	29b. Signature and title of certifier			nse number		29d. Date sig	ned (Mor	th, Day, Year)
$\Omega_{c}$		Patr Gronica- Toll.	Jun	0.0	C.M.E.		Septembe	er 26, 20	006
DX/AK		30. Name and address of person who completed cause of death (I Patricia Aronica-Pollak MD. Assistant Medica	,	111 Penn !	Street Baltin	nore. MD 2120	1		
O <sup>th</sup> Stat	(e	31. Date filed (Month, Day Year) 32. Redistrar's Sign		٠ وم					
Registra	~	OCT 0 4 2006	st Ap	W.	_				

06-07 Dona

06-07494		Please Type or Print in B						
Donald Sealing	1- For State Registrar Certificate of Death Reg. No. 201							
Physicia Medical Exami	AU 1/			Death Day Year er 4, 2006 3. Time of Death 1830 hrs				
(		4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death Oakland	4c. County of Death Garrett				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign				
Director		723-18-5581 1X M 2 F 86 Yrs.	May	24,1920 Country) Maryland				
v any	ı	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Important: If time 75 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	į	Maryland Garrett Bittinger  10e Street and Number	10f. Zip Code	1 Yes 2 X No				
he Mar or 28s	Director		21522	USA				
with the ms 23a be noti	all		Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian, Black,				
r death or iter	Funeral	1 X Yes 2 No	i, specify Cuban, Mexican, Puerto Rican, etc. Yes $2  X $ No specify:					
urs afte tural", antiner	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of work done	Specify: White  16b Kind of Business/Industry				
6 172 hor an "na cal Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life DO NOT use retired)					
within giene her that	dwo	12 Lt. Shi:	ft Commander  18 Mother's Name (First, Mid	MD Dept. of Correction				
215- oe filed ntal Hy ked ot ent, the	Be C	Walter Sealing	Anna Wessel	ade, marger carriente,				
221 hould the man Mer is mar	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing A	Address (Street and Number or Rural Route					
, ML and 2 s ealth a em 27 traum:	ŀ	Jane Lee Sealing/Wife 227 May  20a. Method of Disposition 20b. Place of Disposition		Bittinger, MD 21522  [20c. Location - City or Town, State				
TOFE ages 1 nt of H t: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other	· · · ·	OOA Bittinger Maryland				
altin nit Pa partmen portau		1	me and Address of Facility	00\$ Bittinger, Maryland Grantsville, MD 21536				
		De Sau Human News	man Funeral Homes, P					
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure List only one sause on each line		ry arrest, shock, or heart Approximate Interval Between Onset and Death				
Examiner		Immediate eause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease or condition resulting in death)  Due to (or as a consequence of):	ase					
<b>&amp;</b>	_	Sequentially list conditions, b	<del></del>					
	mine	cause. Enter Underlying Cause  (Disease or injury that initiated						
cecuted n and - transit	cal Examiner	events resulting in death) Last  Due to (or as a consequence of):  d						
ज जं ७		UNPENDED AMENDED						
Box 68760, death certificate be the attending physicic of for use as the buring of for use as the buring the buring of for use as the buring of for use as the buring of for use as the buring of for use as the buring of for use as the buring of for use as the buring of for use as the buring of for use as the buring of the b	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	2 Drugger	23d. Date of delivery				
x 68 h certif tending use as	ician	past 12 months?  4 Pregnant at time of death 5 Othe	I death 3 Ectopic pregnancy er (Specify)	Month Day Year				
Records, P.O. Box 68760, The law requires that the death certificate be exicate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the unit	destring equipping in Boot I	Did tobacco use contribute to the cause of death?				
P.O.	þ	Head Injuries	1	Yes 2 No 3 Probably 4 V Unknown				
rds, require been si	eted			Was an 24b. Were autopsy findings available autopsy prior to completion of cause of				
ecol he law ite has	Completed			yes 2 No 1 Yes 2 No				
Division of Vital Records, rater death or Attending Physician: The law requirms and Directors. After this certificate has been sied in by the funeral director, page 2 should be	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check only one)					
f Vit Physic er this c	၉	examiner 2 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ✓ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		5 Residence 6 Other:				
on on on on on on on on on one fune	ion:	1 Natural 5 Pending Oct 4, 2006 1745 hrs	1 Yes 2 ✓ No Subject					
Visic or Atte fter des Directo	ifica	2 ✓ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,		tion (Street and Number or Rural Route Number, City wn, State)				
Di spital nours a neral I	Certification:	4 Homicide determined (Specify) Barn		County Fairgrounds, McHenry, MD				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death To the Vineral Director: After this certificate has been signed by the attending physici completely filled in by the funeral Director. page 2 should be detached for use as the buri	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner, stated						
F. W. T. 00	Me	29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)				
	D	Mhna Brasse W. M. D.	O.C.M.E.	October 5, 2006				
	VA	30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21201					
	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Month 27, 2006 Street September 2215 Ruth Lorraine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2 F Director 12/11/1923 Pennsylvania 215-14-3301 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? items 23a 32686 West Post Office Road 21853 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Importent: If item 27 is marked other the any injury or other treumatic event, Item 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Brown Edna Pusey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Street/Son 2616 Checkerberry Court, Reston, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/02/2006 | Salisbury, MD 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Signature of Funeral Savice Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONGESTIVE HEART FAILURE Immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical HEART Examiner YEARS SCHEMIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ HYPOTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown Completed PEZ DIATSETES MELLI TUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTENSION 1 Yes 2 No 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? I or Attending Patter death. After 5 Pending investigation 1 Avatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 46962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGIONAL MEDICAL CENTER PENINSULA M.D. M. SHIRA ZI 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 6 2006 Registrar

				partment of Health and Menerificate of Death	ntal Hygiene
ı	Physic	ian	Decedent's Name (First, Middle, Last)     Rose Snell St.John		Date of Death Month Day Year Ctober 2, 2006 1:50 A M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Pineview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Clinton  If Under 1 Year   If Under 24 Hrs.   8 F	Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. last birthda) 7. Age (In yrs. last b	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) A Tabama
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1		10d. Inside City Limits
	e Mary	ctor	Maryland Prince George's District	: Heights	1 □Yes <b>X</b> □ No
	with the a or 28	Director	10e. Street and Number 7701 Fanwood Court	10f. Zip Code 20747	10g. Citizen of What Country?
	deeth	Funerai		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	
920	72 hours after deeth with the Maryland Instural', or Iteme 23a or 28a-f ehow dical Exacilies inval be redilled at	by	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	n, etc.)  Black, White, etc.  Specify: White
21215-0036	n 72 hours "natural",	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Give	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	be filed within 72 hatal Hygiene. Id other then "natuevent, ins Medical	Somp	Elementary/Secondary (0-12) College (1-4or 5+)	ce Manager	Red Cross
and		Be	17. Father's Name (First, Middle, Last) Charles Clifford Snell		rst, Middle, Maiden Sumame) Mae McElvaine
Maryland	d 2 should th and Men 7 le marke traumatic	ပို		ling Address (Street and Number or Rural Ro	
	s 1 end 2 if Health 2 item 27 is			Josephine Rd., Wald	
nor	<u> </u>		LEDOGRAL 2   CHARLAGE	position (Name of ematory or other place)  rans' Cemetery 10-10-	20c. Location - City or Town, State
Baltimore,	pernit. Pag Department Important: any njury o		21. Signature of Funeral Service tipensee M00053	22. Name and Address of Facility 30	035 Old Washington RD
	<u> </u>	H	23a. Part1. Enter the disease, or complications that caused the death. Do not en		OB 156, Waldorf, MD 20604  Approximate  Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. VIII M	ne Z	Interval Between Onset and Death
	/Medical Examiner		Due to for as a consequence of	end Ladere	6 hout
	led Islt	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		214.5
o,	sicien and burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):	vec	- Jea-
8760,	icate be ex physicien s the buria	edicai	d		
Box 6	daath contificate be executed e attending physicien and d for use as the burial-transit	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 rponths?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
0.	at the day by the a tached for	Physician/M	1  Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)	Month Day Year
ds, P	esth; gned be de	ě	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ ✔ 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	e law requir has been si je 2 should	Completed			24a. Was an autopsy findings available prior to completion of cause of
alB		e Con	OF West and the state of the st		performed? death? 1  Yes 2 No 1 Yes 2 No
f <i< th=""><th>Physicien: This certificater al director, p</th><td>To Be</td><td>25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  Hospital: 1 □ Inpatient 2 □ EP/Outpatie</td><td>26. Place of Death Ch ent 3 DOA Cther: 4 V Nursing Home</td><td>seck only one)  5 Residence 6 Other (Specify)</td></i<>	Physicien: This certificater al director, p	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  Hospital: 1 □ Inpatient 2 □ EP/Outpatie	26. Place of Death Ch ent 3 DOA Cther: 4 V Nursing Home	seck only one)  5 Residence 6 Other (Specify)
0 00	ding Ph J. After th funeral		27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. I Work?	Describe how injury occurred
	il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No  Itreet, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
ā	To the Hospital or Attending Physicia within 24 hours after death.  To the Funeral Director: After this cert completely filled in by the funeral direct				
	the Hospital hin 24 hours a the Funeral I	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
	To t	Σ	29b. Signafure and title of certifier	29c License number  2453	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	10-2-06
M	۲   <u>۱</u>   Sta	te	Laxmi N. Berwa, MD, 7700 Old Branch 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	Avenue, Suite C-101,	Clinton, MD 20735
	Registr		OCT 0 3 2006 Keen &	and a	

			1 - For State Registrar	State of Maryland		artment of			al Hygien	2000	32058
	Physic	ion	Decedent's Name (First, Middle, L.	ast)					ate of Death	ay_ Year	3. Time of Death
	/Medi		Ida	Tollefsen				Se	otember	r292000	8:55PM
	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town	n, or Location	of Death	4	c. County of Death	Low
	Funeral			Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Ye		r 24 Hrs. 8. Da	ite of Birth onth, Day, Year	9. Birth	place (State or Foreign
	Director		5//-48-6248	1□ M 2 XF 93	Yrs.	Months Day	ys Hours		onth, Day, Year /17/191:		ngton D.C.
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					IOd. Inside City Limits
	Mary -f sho	tor	MD Somers	Dr.	incess	Anno					1 Nes 2□No
	or 28e	Funeral Director	10e. Street and Number	11.	LIICESS	10f. Zip Cod	е		10g. C	itizen of What Cou	ntry?
	ath w	rai	11974 Edgehill 1				853			USA	
	ter de Items	nne	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No	S. 13. \	Vas Decedent of Yes, specify C	of Hispanic O Juban, Mexica	rigin? (Specify Y an, Puerto Rican,	es or No- etc.)	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>	
036	al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2	Specify	<i>r</i> :		Specify: Whi	t o
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or teme 23a or 28a-f show ther then "natural", or teme 23a or 28a-f show ont, the Medical Examiner must be invitified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Deced	lent's Usual Oci kind of work do	cupation	st of working	16b. I	Kind of Business/In	
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use ret	rired)				
<b>d</b> 2	be filed within 72 hours after death with the Marylan Ital Hygiene. sd other than "natural", or tlema 23a or 28a-f show event, the Medical Examiner must be notified at		12 17. Father's Name (First, Middle, Las	none	Homem	aker	18. Moth	ner's Name (First		wn Home	
ılan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental than aumatic event, the Mental than aumatic event, the Mental than a mental th	To Be	Robert Pagan				He1	en Gitti	inger	•	
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	ľ	19a. informant's Name/Relationship				eet and Numb	per or Rural Rout	e Number, City	or Town, State, Zip	Code)
	1 and 2 Health tem 27		George Stephense					ocomoke	_	4D 21851	
nor	ages ant of I it: If it y or o		1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Speci	_ I tellioval itotil State		sition (Name of natory or other p	,			ocation - City or To	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		1. Signature of Funeral Service Lice			, Name and Add Lnman Fi		10/02/20	Jub Sal	lisbury,	Maryland
<u>m</u>	Dep trup		man XIII	M00295					rincess	Anne, M	21853
П			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death. one cause on each line.	. Do not ente	er the mode of o	tying, such as	s cardiac or respi	ratory arrest,	,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	alleteriosel	ecolis	Caro	liova	seeles	Ilesa	dee	Onset and Death
	Examiner			Due to (or as a consequ	ence of):						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent	ence of):						
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transif	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
8760,	be ex sician burial	ai E		Due to (or as a consequ	ence or):						
687	ifficate g phys as the	edicai		_ d							
Вох	eath certific attending p for use as t	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregna	nev			23d. Date of delive	ory
О	at the dea by the att tached fo	Physician/Me	in the past 12 months?  1  Yes 2 No 9 Unknown	4☐Pregnant at time of dea		Other (specify)			_	Month	Day Year
Δ.	that the ed by detac		Part II. Other significant conditions	contributing to death but not resul	Iting in the un	derlying cause	given in Part	I. 23	Be. Did tobacco	use contribute to th	e cause of death?
Records,	quires tha n signed uld be det	ed by	advanced	2 Demen	tea			11	1 ☐ Yes 2	No 3 Prob	abiy 4 Dunknown
006	e law requir has been si je 2 should	Completed	Dinbetes	mellit	1			24	a. Was an	24b. Were auto	osy findings available
	The ate h page	Com	Essential "	Heparton	ries	>		1[	autopsy performed? □Yes 2 <b>2</b> No	death?	npletion of cause of 2MNo
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	e of Death (Chec			
of	g Phys ter this teral di	); To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	28c. In	iury at		Residence	6 ☐ Other (Specify	")
ion	Attending r death. sctor: After oy the funer	ation	1. KNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) n	Injury	W	ìork? □Yes 2□	]No			
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		ne, farm, stre	et, factory, offic	е		cation (Street ar	nd Number or Rura e)	l Route Number,
	Hospital		29a. Certifier 1 ★ Certifying P	nysician: To the best of my know	vledge death	accurred at the	timo dato ar	nd place, and du	a to the equec/o	) and manner as at	
	he Hos n 24 h he Fur pletely	edical		miner: On the basis of examination and manner stated.	on and/or inv	estigation, in my	y opinion, dea	ath occurred at th	e time, date an	d place, and due to	the cause(s)
	To the within 24	Σ	29b. Signature and title of pertifier	200	2	29c. Lice	nse number			ate signed (Month,	
ı			Jugun th	. Deller	no.	12	950	95	10	-02-2	2006
			30. Name and address of person who		_		מ עפס	p Gali	Sanov	Mn n	G AT I
	Sta	te	31. Date filed (Month, Day, Year)	32. Registar's Signatu	ire		~~/ V)	K, JALL	-bary,	C() 21	001
	Registr	ar	OCT 03	2006 Men	15	Check	•				

md558 90/60/6

Ida N. Tollefsen

				1- For State of Maryland /	Department of Health and Me  Certificate of Death	-	ne nns	32959
_		Physici		Decedent's Name (First, Middle, Last)     Elva Eileen Vickers		2. Date of Death Month	Day Year	3. Time of Death 5:35 AM
	1	/Medic Examir		4a. Fecility Name (If not institution, give street and number)  MANOKIN MANOR	4b. City, Town, or Location of Death PRINCESS ANNE		4c. County of Death	ET
		Funeral Director		5. Social Security Number  213-22-5343  Usuel Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last bite) 78	Vrs Months Days Hours Min.	B. Date of Birth (Month, Day, Ye March 1,		ace (State or Foreign try) yland
١		Maryland -f show	tor	10a. State 10b. County 10c. City, Tow MD Dorchester	on or Location  Cambridge		10	0d. Inside City Limits 1 XYes 2 □ No
10	3	th the	Funeral Director	10e. Street and Number 214 Killarney Road	10f. Zip Code 21613	10g.	Citizen of What Count	try?
0	2	tems 23	unera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - America Black, White, e	
RS	9003	hours afte	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Wh	ite
VICKER	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exantrust must be inclined at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  line worker		. Kind of Business/Ind	
710	nd 2	be filed vial Hygie	Be Co	11 17. Father's Name (First, Middle, Last)	18. Mother's Name (		electronic	
	Maryland	should but Meni	ည	Phillip James Higgins  19a. Informant's Name/Relationship (Type, Print)  19b.	Margaret  D. Mailing Address (Street and Number or Rural F		v or Town State Zin	Code
	, Ma	and 2 sealth arm 27 is		Betty Jo Mowbray daughter 8	3730 Tips Lane, Westove		21871	
Ø	Baltimore,	ages 1 ent of H nt: If ite y or oth		A Paragraphic State	f Disposition (Name of party, crematory or other place)		Location - City or Tov	
三三	<b>3alti</b> i	permit. F Departme Importar any injur		21. Signatur, of Funeral Service Licensee	and Veterans Cem. 10/5, 22. Name and Address of Facility Tho		Hurlock, MI eral Home H	
Ш		<b>7</b> □ 7 € 6 0		23a. Part). Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	700 Locust St., Camb			Approximate
•		Pnysician		Immediate Cause (Final disease or condition	ONARY FIBROSIS.			Interval Between Onset and Death
	1	/Medical Examiner		Due to (or as a consequence				
		led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	of):			
	90,	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence	of):			
	687	tificate L g physic as the b	ledicai	d				
	P.O. Box 68760,	or Attending Physicien: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliven Month D	y Day Year
	ds, P	signed b	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		o use contribute to the	
	Division of Vital Records,	s law requir has been si e 2 should	Completed			24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
	ital F	en: The tificate tor, pag	Be Cor	25. Was case referred to medical	26. Place of Death (C	performed? 1 Yes 2 1		!□ No
	of Vi	Physici this cer al direc	٩	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)	
	ion	ath. r: After e funer	ation	27. Manper of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident   28a. Date of Injury (Month, Day Year)   18b. 1	Fime of njury 28c. Injury at Work?  M 1 Yes 2 No	d. Describe how inj	jury occurred	
	Divis	al or Atte after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	. Location (Street a City or Town, Sta	and Number or Rural i te)	Poute Number,
		To the Hospital or Attending Physiclen: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge 2 Medicel Exeminer: On the basis of examination and and manner stated.	o, death occurred at the time, date and place, and d/or investigation, in my opinion, death occurred	I due to the cause( at the time, date a	(s) and manner as stat nd place, and due to the	ted. he cause(s)
_		To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Da	ay, Year)
				30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)	Och	ober and	2006
				1415 S. DIVISION ST, SAUSBURY	MD 21804.			
		Star Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	MD 21804.			

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hyg	iene 006	32960
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat	th Dav Year	3. Time of Death
	/Medic Examir		Lawrence L. Vallario  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		oer 26, 2006	12:05 A **
	LXAIIIII	iei	Anne Arundel Medical Center	Annapolis		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day,	9. Birthol	lace (State or Foreign
	Director		3/9-30-31/3	Monto Bays Hoors Ame.	12-10-1		ington, DC
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10	0d. Inside City Limits
	Mary First	tor	Maryland Queen Anne's Gra	nsonville			1 ☐ Yes 2 🛣 No
	or 288	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Coun	try?
	23a c	alD	115 Bayview	21638		USA	
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	I. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 1959—63	1 ☐ Yes 2 X No Specity:		Specify: Wh:	ite
9	be filed within 72 hours after death with the Maryland hal Hygiene.  do other then "natural", or iteme 23a or 28a-f show event. I've Medical Examinar must be rotified at		15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Ind	lustry
215	thin 7 e. en "n	Completed	(Specify only highest grade completed) (Gin	re kind of work done during most of work DO NOT use retired)	ing		•
2	ygien yerth	Con	12th	teamfitter		Construct	ion
and	should be filed vand Mental Hygies marked other turnatic svent, It	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		,	
2	should be nd Mental marked c	은	Joseph F. Vallario  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Lu ling Address (Street and Number or Rur	cille Be		0-4-1
Ma	lith an 27 is traus			Mt. Pleasant Drive			Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked sny injury or other traumatic sv		20a. Method of Disposition 20b. Place of Dis	position (Name of		20c. Location - City or Tov	wn, State
E	Page nent o int: If iry or		La bunal 2 Cremation 3 Hemoval from State	ematory or other place) cans Cemetery 9-29	-06	Cheltenham,	MD
alti	mit. porta porta y inju			22. Name and Address of Facility Ge			
_	99 E 29		Jarya o alla	2973 Solomons Isla	nd Rd. E	dgewater, M	21037
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arre		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burlat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
P.O. Box 68	ath certific ttending p or use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
Records, F	w requires that the der been signed by the a should be deteched to	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the	e cause of death?
000	ne law requ has been ge 2 shoult	Completed	,		24a. Was ar		sy findings available
	The ate has page	E O			autopsy perform	ned? death?	ipletion of cause of 2 No
ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?	26. Place of Deat			
ot o	Physi this c al dire	P -	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			nce 6 Other (Specify)	1
u C	ding I	ion	27. Manner of Death 28a. Date of Injury 28b. Time Injury (Month, Day Year) 27 Injury 28b. Time Injury	Work?	28d. Describe ho	w injury occurred	
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	1 2 ☐ Accident     investigation       3 ☐ Suicide     6 ☐ Could not be determined       4 ☐ Homicide     determined   28e. Place of Injury · At home, farm, s building, etc. (Specify)		28f. Location (Str. City or Town	reet and Number or Rural , State)	Route Number,
	e Hospita 24 hours e Funeral etely filled	edicai C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the ca red at the time, da	use(s) and manner as sta ite and place, and due to	ited. the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, D	ay (Year)
			V 11 21	05518		9/26	16
	. ~ .	-	30. Name and address of person who c'm leted cause of death (Item 23a) (Type	, Print) A	91	1 . 1	)
	197		A in a land to	one Averdel	I The	dical	enter
7.5	Sta Registr	-	31. Date filed Month, Day, Year) SEP 2 8 2006 32. Registrar's Signature	had s			

State of Maryland / Department of Health and Mental Hygien 006 32961 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day LULA MAE WILLIAMS 10:00 PM /Medical SEPTEMBER 23, 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Oay, APRIL 8, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ X F Director 256-62-0565 65 Yrs. GEORGÍÁ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND 1 Yes 2 No MONTGOMERY 7 is marked other then "natural", or items 23a or 28a-f traumatic event, the Medical Examinar must be notifie SILVER SPRING 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11200 LOCKWOOD DRIVE, APT #720 Funeral 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSE'S AIDE HEALTHCARE SERVICES 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 7 is marked ot Be 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be Imeni of Health and Menta tant: If item 27 is marked jury or other traumatic ev JOSEPH BROWN ROSA LEE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tr DERRICK E. WILLIAMS/SON 12290 GREEN MEADOW DRIVE, COLUMBIA, MARYLAND 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. PARKLAWN MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 09/30/2006 ROCKVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician all M disease or condition resulting in death) /Medical Examiner Cirrhosis 1 Im our L Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): anding physicien and use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ٥ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy certificete director 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To this After the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. ector: / 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and ville of centifier 29c. License number 29d. Date signed (Month, Day, Year) person o completed cause of death (Item 23a) (Type, Print) 20851 Georgetown Rd., Betherda, ta 8600 old 31. Date filed (Month, Day, Year) Hadistrar's Signature State

Registrar

09/23/2006

X [illiams,

			1 - For State RegistrarAMEND	#10e.nerI	State 0 3+.10/3/0	of Mar 16.DPS	ryland S.McCo	/ De	par <i>erti</i>	tment ( ificate	of H of L	ealth a D <i>eath</i>	and Me	ental Hy	giene Reg. No		6	32962	
	Physici		Decedent's Name (Fit MARCELLA JE.)	irst, Middle, La	st)		,							2. Date of De Month OCTOBER	Day		əar	3. Time of Death 2:15 A M	
	/Medic Examin		4a. Facility Name (If not HOLY CROSS	_	e street and no	ımber)			4	4b. City, To		Location of SPRING			4c.	County of MONTO		RY	
	Funeral Director		5. Social Security Numb		ex □M 2 <b>∑</b> ]F	7. Age	(In yrs. las	t birtho	"	If Under 1 'Months E		If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D. 7/16/1	ay, Year)	9 W	Birthp Cour ASHI	olace (State or Foreign ntry) NGTON DC	)
	pu s		Usual Residence of Dec	cedent b. County		1	10c. City,	Town o	rloca	ition								0d. Inside City Limits	_
	f eho	ŏ		HOWARD			LAU										- 1	1 ☐ Yes 2 🛣 No	
	3a or 28e-	I Director	10e. Street and Number		_	ıd Wa	ıy			10f. Zip Co 2072					10g. Cit	izen of Wh		ntry?	_
036	be filed within 72 hours after death with the Maryland ital Hygiene. ed other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examinar must be inclified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	-2.5	12. Was Dec Armed F 1 Tyes If Yes, G Year or I	orces? 2 [ <b>X</b> No ive				as Deceder /es, specify		spanic Orion, Mexican	gin? (Spec , Puerto R	ofy Yes or Notican, etc.)	D-	14. Race - Black, Specify:	White,		
2-0	72 ho	eted	15. (Specify o	Decedent's Econly highest gra	ducation ade completed	)		(0	ive kir	nt's Usual (	done d	urina most	of workin	a	16b. K	ind of Busin	ess/in	dustry	Т
21215-0036	within lene.	Completed	Elementary/Secondar	1		(1-4or 5+)	)	lin	e. DC	OCOL OF	retired)	_		3		NSA	1		
	al Hygie sother vent,	BeC	17. Father's Name (Firs	st, Middle, Last,	)							18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)			
yla	should be ind Mental marked o umatic eve	To	ALLEN CO									HE	LEN SU	CHTER					
Maryland	d 2 sh th and th and 17 is m traum		19a. Informant's Name/ GARY WESTERME		Турө, Print)					Address (S RLY BUD				Route Numb	er, City o	or Town, St	ite, Zip	Code)	
Baltimore,	eges 1 and 2 should b nt of Heelth and Ment t: If Item 27 Is marked y or other traumatic e		20a. Method of Disposit	tion	Removal from	State		to the same of the	_	ion (Name tory or othe		-		1te	20c. Lo	ocation - Ci	y or To	own, State	
<u>H</u>	permit. Peges Department of I Important: If Its any Injury or o		4 Donation 5	Other (Specif	y)		FORT	LINC		CREMAI			10/3/2			ENTWOOL		D	
Ba	Depa Impo		▶ Moe	lin Ti	Klove	×								S-RINAL SILVER				4	
E	Physician		23a. Part1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only	one cause on	each line	he death. FAILUR		enter	the mode of	of dying	, such as	cardiac or	respiratory a	irrest,			Approximate Interval Between Onset and Death WELKS	Î
	/Medical Examiner						conseque ATIC B			ANCER								1 YEAR	
	nsit	Examiner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injur	diate		(ur as a	conseque	nce of):											
58760,	icate be executed physician and s the burial-transit	edicai Exar	that initiated events resulting in death) Last	l	c. Due to	(or as a	conseque	nce of):	:										
_	ntificat ng phy as th		IF FEMALE:																
P.O. Box	The law requires that the death certifi site hes been signed by the attending paga 2 should be detached for use as	Physician/Me	23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nths?		birth 2 nant at tir	pregnanc Fetal de me of deal	eath		ctopic pregi Other (s <i>peci</i>						23d. Date o Month		ery Day Year	7)
	w requires that been signed by should be deta	by	Part II. Other significan	nt conditions o	contributing to	death but	not resulti	ng in th	e unde	erlying cau	se give	n in Part I.				37		ne cause of death?	
Division of Vital Records,		Completed				. <u>.</u>							-	24a. Was auto perfe 1 \( \text{Yes} \)	DSV	24b. We prio dea 1	e auto r to co th? Yes	psy findings available mptetion of cause of	
Vita Vita	icien: Th certificete rector, pag	Be	25. Was case referred to examiner?	to medical	Hospital: 37						! Otho		of Death	(Check only	one)		-		
ō	Phys r this ral dir	٠ <u>.</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death		Hospital: 1 X	Inpatient of Injury	2 🗆 EF	NOutpa Bb. Tim			Othe	4 🗆 140		e 5 🗆 Res			Specif	y)	
on	Attending Physicien: r deeth. ector: After this certific by the funeral director.	ation	37	Pending investigation	28a. Date ( <i>Moi</i>	nth, Day Y	Year)	Inju		м	Injury Work	? ′es 2⊡t	1	30. 50001.50		,, 00001100			
Divis	efter deeth Director: In by the	Certification;	3 Suicide 6 4 Homicide	Could not be determined	280. Plac	e of Injury ling, etc.	y - At hom (Specify)	e, farm	, stree	t, factory, o	ffice		21	Bf. Location ( City or To			or Rura	il Route Number,	
	To the Hospitel or Attent within 24 hours efter deeti To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exar	niner: On the i	e best of pasis of e	xamınatio	edge, d n and/o	eath o	occurred at stigation, in	the tim	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s)	and mann d place, and	er as si	tated.  the cause(s)	_
	To th within To th comp	Me	29b. Signature and title	of certifier		7				29c. L	icense	number			29d. Da	te signed (/	Aonth.	Day, Year)	
}			Jin	d NI	/fu	m	elm	0			D.	35996				10/1/2	006		
-	5		30. Name and address							int) #400; V	ЛНЕА'	TON MD	20902						
	Sta Registr		31. Date filed (Month, D	Day, Year)		Registrar'	s Signatur	Θ											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 19b, 10/13/06, LDB, DORState of Maryland / Department of Health and Mental Hygiene 0 0 5 1- State Amended 20b, 10/4/06, LDB, DOR Registrar 32963 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2230 PM Wright reatember 26,2006 thri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hester River Hospital hestertown enter If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2 1 F Hours Yrs. Director Marylan Usual Residence of Decedent 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show a' Hygiene i other then 'nature!', or lieme 23a or 28e-1 ehoi vent. <u>tre Medical Examiner must be notilied al</u> 1 Yes 2 No Completed by Funeral Director Anne's 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21617 321 Street berty U 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 12 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Someone else's Home Work permit. Peges 1 and 2 should be filed to Department of Heelth and Meniel Hygie Importent: If Item 27 is marked other tile eny injury or other fraumatic event. The page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Winchester 2 Foreman Mailing Address (Street and Number of Rural Route Number, 2050 School Steet, Apt. 40 19a. Informant's Name/Relationship (Type, Print) Harriet J21-1V: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Veterans 22. Name and Address of Facility Home, 21. Signature of Funeral Service Licensee MD. 21613 510 Washington St. 23a. Part / Enter the disease, or complication. Lat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carse an each ling. Approximate Interval Between Onset and \_\_ath Immediate Cause (Final Physician disease or condition resulting in death) /Medical Rua to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed 101 attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2□ No 1 ☐ Yes 2 No 1 Tes Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death |Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 Impatient Medical Certification: To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injun s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D61321 9/27/06

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Chestertown, MD

21620

30. Name and address of the who completed cause of death (Item 23a) (Type, Print) Semra Sahinci, M.D., 120 Speer Road, (

2 2006

32. Registrar's Signature

32964 State of Maryland / Department of Health and Mental Hygien

		•	1 - State Registrar			Cert	ificate of	Death			g. No.	0 323	04
	Dhorisi		1. Decedent's Name (First, Middle							Date of Death	1	3. Time of the	
	Physici /Medio		EMMA	L. WI	LLIAMS				(	OCTOBER	1 <sup>ay</sup> 2006 <sup>Y</sup>	5:31	. Рм
	Examin		4a. Facility Name (If not institution WASHINGTON	n, give street and number) ADVENTIST HO	SPITAL		4b. City, Town, o	PARK			4c. County of I	Death GOMERY	
	Funeral Director		5. Social Security Number 043–18–7428	6. Sex 7. Ag	e (In yrs. last birt 92		If Under 1 Year Months Days	If Under a	Min.	Date of Birth (Month, Day, AN 19	Year)	Birthplace (State or Country) ORTH CARO	
	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-f ahow he Madical Examinar maat be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  DC  10e. Street and Number		10c. City, Town		,DC			10	g. Citizen ol Wha	10d. Inside Cit	•
	ath with t	rai Dir	3001 BLADENSB				10f. Zip Code 2001				U.S.A		
036	d within 72 hours after death with the Marylan jene. r than "natural", or itema 23e or 28e-f show the Madical Examinar must be notified at the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☒ Widowed 4 □ Divorced	If Yes Give		1	as Decedent of H Yes, specify Cuba ☐ Yes 21☐ No			y Yes or No- an, etc.)		American Indian, White, etc. BLAC	K
)-CLZL	within 72 h ane. than "natu ne Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5		(Give kil	nt's Usual Occup ind of work done O NOT use retired	during most	t of working		6b. Kind of Busin	ess/Industry	· ·
Maryland 21215-0036	be filed htal Hygi ed other avent, I	To Be Co	9th 17. Father's Name (First, Middle, HENRY THURBER			OK_		18. Mothe	or's Name (F	irst, Middle, M	aiden Sumame)		
	s 1 and 2 should I Health and Men Item 27 is marke other traumatic	-	19a. Informant's Name/Relations		- 1							te, Zip Code)209 SPRING, MD	
Baltimore,	Pages 1 a nent of He int: if item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (S	_	1	y, crema	tion (Name of atory or other place CREMATO	· 1	Date 0/5/2		Oc. Location · Cit	or Town, State  MARYLANI	D
Balt	permit. Pages Depertment of I Important: if its eny injury or of		21. Signature of Edneral Service	Licensee	1		Name and Addre				KINS FUN R,MARYLA	ERAL HOME ND 20785	
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each lin	d the death. Do not not not not not not not not not no			ng, such as	cardiac or re	espiratory arre	st,	Approximate Interval Betw Onset and D	veen
	/Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ATHEI	a consequence on ROSCLERO a consequence of ONIA	TIC	HEART D	ISEASI	E				
68/60,	eath certificate be executed attending physicien and for use es the burial-transit	Medical Ex	resulting in death) Last	Due to (or as	a consequence o	of):							
O. Box 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnancy Other (specify)	<u> </u>			23d. Date of Month		ear
rds, P	ires tha signed I be de	Ď	Part II. Other significant conditi	ons contributing to death b	ut not resulting in	the und	lertying cause giv	ren in Part I.				te to the cause of de	
I Kecord	The law ete has b page 2 sl	Completed								24a. Was an autopsy perform	ed? deat	e autopsy findings a to completion of ca h? Yes 2X No	vailable use of
Z Z	ician: Th certificete rector, pag	Be (	25. Was case referred to medica examiner?				Lou		ol Death (C	heck only one	)		
0	Phys this ral dii	2	1 ☐ Yes 2 📆 No 27. Manner ol Death	Hospital: 1 ☐ Inpatie				4 🗆 140			nce 6 Other (	Specify)	
DIVISION	ttending death. ctor: After	Certification:	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation not be 200 Rhos of Init		njury		k? Yes 2□N	No			r Rural Route Numb	200
2	pital or ours afte leral Dir filled in		4 Homicide determ	building, etc	c. (Specify)			me date and		City or Town,	State)		
	To the Hoe within 24 hor Fo the Fun completely	Medical	(Check only 2 Medical one)  29b. Signature and Itle of certifies	Examiner: On the basis of and manner sta	f examination and	Vor inve	stigation, in my o	pinion, deat	th occurred	at the time, da	te and place, and	due to the cause(s)	
	(3)		30. Name and address of person	who complete cause of d	leath (Item 23a) (	Type, Pr		609	?	C	cf 20	nd 2006	•
	de	i i	RAMAN R. TUI					ITE 20	)2 GAI	THERSBU	IRG, MARYI	AND 20878	8
	Sta Registr		31. Date liled (Month, Day, Year)	Slow 32. Registra	ar's Signature	,							
DI .	W147 D 410	004											

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Ma	ryland /	Departme Certifica				enze UUb g. No.	32960
¥	Physicia	an	1. Decedent's Name (First, Middle, Las Charles W. Wegner	•					2. Date of Death Month Septembe	Day Yes	3. Time of Death 06 4:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		,	ity, Town, or	Location of Death		4c. County of D	eath
			Genesis Eldercare  5. Social Security Number 6. Se		k Cent		der 1 Year	Annapo	lis  8. Date of Birth		e Arundel
	Funeral Director			2X M 2 □ F	67	Yrs. Month		Hours Min.	June 14,	1939	Birthplace (State or Foreign Country) Illinois
-	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Location					10d. Inside City Limits
	Maryis	tor	Maryland Anne Ar	undel			Anna	apolis			t <b>y∑</b> {Yes 2 ☐ No
	or 28s	Director	10e. Street and Number	7 E	7	10f.	Zip Code	21403	10	og. Citizen of What	
	ns 23a	Funeral	710 Americana Dri	12. Was Decedent E		13. Was De		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Race - A	American Indian,
320	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, I're Miclical Exercit at mind to rottlies at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N ff Yes, Give Year or Dates:	o		specify Cuba s 2XINo	Specify:	Hican, etc.)	Specify: V	vhite, etc. V <b>hite</b>
212-0030	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	a. Decedent's U (Give kind of life, DO NO	work done o	during most of work	ang	16b. Kind of Busine	
7	within iene. then	omp	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+) A			, e Assista	nt	House of Represen	r ntatives
yland	ald be filed fental Hygi rked other ilc event, L	Be	17. Father's Name (First, Middle, Last) Charles W. Wegner						e (First, Middle, M Anderso	Maiden Sumame)	
Mary	permit. Pages 1 and 2 should be Department of Health and Mental important: if item 27 is marked any injury or other traumatic events.	J.	19a. Informant's Name/Relationship ( Margaret Kees Wee							City or Town, Star Annapolis	te, Zip Code) S, MD 21403
galtimore,	es 1 ar of Hea If Item or other		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □	Removal from State	cemet	of Disposition ( ery, crematory	or other plac	Θ)		20c. Location - City	
	artment ortant: injury		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Balti	more Cr					e, Maryland eral Home
ŭ	Depriming and and and and and and and and and and		Michael (	2 Don	7					Annapol:	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each iin	Θ.	not enter the r	mode of dyin	g, such as cardiac	or respiratory arre	est.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Dement		e of):					3+ years
	Examiner		Sequentially list conditions,	b							
2	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	e of):					
Ď,	cate be executed physicien and sithe burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequence	e of):					
38/60,		dicai	•	. d							
). Box (	at the death certifi by the attending i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	th 3 Ectop	ic pregnancy r (specify)			23d. Date of Month	f delivery Day Year
s, P.O	ss tha	by Phy	Part II. Other significant conditions of Diabetes Mellitu		ut not resulting	in the underlyi	ng cause giv	en in Part I.			te to the cause of death?
ord	w require been sign		Addison's Diseas						1 ∐ Ye		Probably 4 Unknown e autopsy findings available
Rec	hysician: The law his certificate has E I director, page 2 s	Completed	Coronary Artery						autops	y prior ned? deat	to completion of cause of
/ital		Be C	25. Was case referred to medical examiner?				0#		th (Check only on		
0	Physi r this c sral dire	To t	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of fnjur	nt 2 ER/0	. Time of	DOA Oth	4 Minursing H		ow injury occurred	Specify)
ion	ending Physath. or: After thi	ation	1 Natural 5 Pending investigatio	1	/ Year)	Injury M	1 🗆	k? Yes 2 □No			
Division of Vital Records,	al or Attend s after death il Director: /	Certification;	3 Suicide 6 Could not b 4 Homicide determined			farm, street, fa	dory, office		28f. Location (St City or Town		or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 12 Certifying Pt (Check only 2 Medical Exer	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death occur and/or investiga	rred at the tir ition, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of pertifier	/	24 .		29c. Licens		2	9d. Date signed (A	
			Joylo Fr	NW 11	7. D.	) (T-v 5)	ט	17965		Septemb	er 26, 2006
			30. Name and address of person who Inc. Joseph Frie	completed cause of dend 116 De	efense	Highway	, Suit	te 400 A	nnapolis	, Marylar	nd 21401
6	Sta Regist	ate rar	31 Date filed (Month, Day Year)	Registra	ar's Signature	Speech	2				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mary	land / Dep	artment of F	lealth and		giene 006	32966
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
37.	Physicia /Medic		John R. Woods, Sr.						er 25, 200	6 5:54 P <sup>M</sup>
7	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	or Location of De	eath	4c. County of Dea	
642			10809 Javins Stree			Glenn Da		dre o Day (Bit	Prince G	
	Funeral		5. Social Security Number 6. Sex 1以 1 以 1 以 1 以 1 以 1 以 1 以 1 以 1 以 1 以	M 2□ F 7. Age (In	yrs. last birthday, Q Yrs.	Months Days		fin. 8. Date of Birt (Month, Da 10/10/1	y, Year) Was	thplace (State or Foreign puntry) hington, DC
*	Director		Usual Residence of Decedent	0	0			10/10/1	.737   Was	illigeon, bo
	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene. It marked other than "natural", or Items 23e or 28ea-f ahow other treumatic avant, the Medical Examinar must be notified at		10a. State 10b. County	100	City, Town or L	ocation				10d. Inside City Limits
		ctor	Maryland Prince Geo	rges G	lenn Dal	.e				1 X Yes 2 No
		Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
(0		To Be Completed by Funeral Director	10809 Javins Stree			20769			JSA 14. Race - Am	nden Indian
			11. Marital Status  1 □ Never Married 2 ☒ Married	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ∑ Yes 2 ☐ No</li> </ol>	in U.S. 13.	Was Decedent of If If Yes, specify Cub	an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	Black, Whi	
93			3 Widowed 4 Divorced	If Yes, Give Year or Dates: 154	-'58	TLI Yes 201 NO	<i>Зр<del>в</del>спу</i> :			hite
5-0			15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Business	
12	within iene.		Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	(a)		Fire Depar	rges County
d 2	e filed al Hygie other vant, II		12 17. Father's Name (First, Middle, Last)		Firem	lan	18. Mother's	Name (First, Middle,	*	
Maryland 21215-0036	should be nd Mental in marked o		Earle W. Woods				France	es Groshor	ı	
ary	2 should and Men Is marks eumatic	-	19a. Informant's Name/Relationship (Typ	e, Print)		•			er, City or Town, State,	
	is 1 and 2 of Health a item 27 le		Carla J. Woods/ Wi	and the second second			Street		Le, MD 2076	
Baltimore,	of He of He or oth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Re		Ob. Place of Disp cemptery, cre Mary	osition (Name of matory or other pla Land	сө)	Date	20c. Location - City or	Town, State
Ë	Pag ment tant:		4 Donation 5 Other (Specify)	1	Veterans	Cemetery	09		Crownsvil	
Bal	permit. Pages. Department of It Important: If its any injury or ot once.		21. Signature of Funeral Service License	8	1				Evans Funde, MD 2071	5
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death							
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition a. Multiple Myelome Gunos							
			Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):							
		Examiner								
	uted d ansit									
o,	te be executed ysicien and te burial-transit	Еха								
3760,	# × 9	Ical								
( 68	death certifica e attending ph id for use as th	Med	IF FEMALE:							
Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)					23d. Date of de Month	23d. Date of delivery  Month Day Year	
o.	at the de by the stached	iyslo								
Φ.	that ned b	by Pr	Part II. Other significant conditions con	ditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the						o the cause of death?
Records,	quires in sign uld be	Be Completed b	Kidney Failure 1 1 4. Was a autops					es 2. 2 No 3. Probably 4. Unknown		
ဝ	: The law requires that the cate has been signed by th page 2 should be detache									
Ä					F			erformed? death?		
Vital	sician: Th certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
of	ding Phys h. After this funeral di	2	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		2 ER/Outpatie	ALL SU DOA			d. Describe how injury occurred	
		Certification;	1 Aatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 ∏ Yes			ork? Yes 2 No			
Division			3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Ö	tal or Ars after el Director	Cert	4  Homicide determined	building, etc. (S	uilding, etc. (Specify)  City or Town, State					
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certiflier  (Check only one)    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	within To the Comple	Me	29b. Signature and title of centrier 29c. License number					29d. Date signed (Month, Day, Year)		
1 ( James B Centre mos D31602						02	9/27/6			
			30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  George Casundayh BD 4201-Mitchellville Rel Bower Mc 20716							
			31. Date filed (Month, Day, Year)	/ Donistrar's	4201-	Metchell	ville Ko	& Bou	ie, Mol	20716
	Sta Regist	ate rar	SEP 2 8 200	6 Basin	10 14	and I				

			1 - State Registrar	State of Marylar		artment of H			g. No.		
	Physicia /Medic Examin Funeral Director		Decedent's Name (First, Middle, Last)      Deborah Armet			Month	Day Year er 28, 200				
		-01	4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Death			4c. County of Death			
			Frederick Memorial  5. Social Security Number 6. Sex	Hospital 7. Age (In yrs.	(a at hirthdau)	Freder		9 Date of Birth	Frederi		
				M 2K) F 54	Yrs.	Months Days	Hours Min.		,1952 Was	rthplace (State or Foreign ountry) hington	
yland	Mow T	Director	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. fnside City Limits	
е Ма	Sa-f e		Maryland Frederick	a			1 ☐ Yes 2 🖸 No				
with th	perfect. Fages I am 2 should be little within 72 hours and obsument into maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number	3737 Spicebush Drive			10f. Zip Code 21704			ountry?	
death		Funerai		2. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H 1 Yes, specify Cuba		Specify Yes or No-	USA 14. Race - Am		
ours after		by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 Tes, specify Cuba 1 ☐ Yes 2 【XNo	Specify:	to nicati, etc.)	Black, Wh	hite	
hin 72 ho		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
ed wit		To Be Com		5+	Cor	unselor			Education		
d be fil			17. Father's Name (First, Middle, Last)  Richard	vans			18. Mother's Na	me (First, Middle, M	aiden Sumame) Freen		
should and Men			19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address (Street			City or Town, State,	Zip Code)	
and 2	m 27 ii ner tra		David Williams/ Hus				h Dr. Ur	bana, MD			
Pages 1	nent of Hi nt: If ite ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	cemetery, cren	sition (Name of natory or other plac on Nation		Date 2 20/2006	oc. Location - City of Arlington		
permit. Departn	Deporting any nju		21. Signature of Funeral Service Licenses  22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike Frederick, MD 21702								
	Physician /Medical Examiner		23a. Part Enter he disease or complic shock, or heart failure. List only one						st,	Approximate Interval Between	
										Onset and Death	
			Due to (of as a consequence of):  Mota state			Breast Causes				5 years.	
P		lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse	s a consequence of):						
xecute		Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of								
te be	ysicier ne buri	edical E	d								
ertifica	ang ph		IF FEMALE:								
ne death o	the attend hed for us	Physician/M						23d. Date of de Month	olivery Day Year		
thatth	detac		Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco						acco use contribute t	use contribute to the cause of death?	
aduires	To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ed by	Cancer cachezia 1 1 Yes 2					s 2□No 3□P	No 3 Probably 4 Unknown		
law E		Completed						24a. Was ar autopsy	prior to	utopsy findings available completion of cause of	
1 i		-						perform 1 ☐ Yes 2	☑No 1 ☐ Ye	s 2□No	
sicial		o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Spec						20161)		
E E		-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun		28d. Describe ho		scily)	
tendir Jeath.		catic	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, streen building, etc. (Specify)			M 1 ☐ Yes 2 ☐ No					
ital or A		Certification:				City or Tow					
Hospi		Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the neuse(s) and manner as stated.  Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To th		Me	29b. Signature and title of certifier 29c. License number 29d. Date si					d. Date signed (Mon	th, Day, Year)		
~			30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) 46 B Thomas Jahnson Drune FREDERICH, MD 2170					2000			
16	)		30. Name and address of person who con	rpleted cause of death (fte	m 23a) (Type,	we FR	LEDER	rick, M	0 2170	2	
	Sta		31. Date filed (Month, Day, Year)	32. Régistrar's Sign	atura	Card a					

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 0:03 AM **Physician** 2006 0 /Medical 4c. Gounty of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ampus omerset lace f Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 218-34-8825 1 ■ M 2 F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c City, Town or Location show 27 is marked other than "neturel", or items 23a or 28e-f shor traumatic event, the Madical Examinar must be multipled at 1 Yes 2 No Funeral Director MD 50 morget 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21853 U.S.A 2109 Lace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by 13/ac 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TO USE WI aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson HARRY Marters မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) La. Informant's me/Relationship (Type, Print) item 27 l 822 20074 Daughter talcon DY ara 20b. Place of Disposition (Name of cemetery, crematory or other place) Dåte 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ot
once. 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cometers 10-07-2000 22. Name and Address of Escility Arthony E. Wall Funeral 21. Signature of Funeral Service Licensee Home Thing Werd Princess Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Apterioscherotic Caldiovosular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E 29a. Certifier 1🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 2187 305 ENTH ocomoke 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygien & U U b For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25, Month **Physician** September 2006 9:28 Leona Adaline Wilkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) **Funeral** 1□M 2XF 12/17/1921 Director 218-66-3921 84 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23s or 28s-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Gambrills Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21054 2604 Chapel Lake Drive #302 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ģ 3 ₺ Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be Department of Health and Mental Important: If Iem 27 is marked of any injury or other traumatic even sone. Martha Lillian Allen William Joseph Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Chapel Lake Drive #303 Gambrills, MD 21054 Melvin L. Wilkins/ Son Baltimore, 20b. Place of Disposition (Name of cametery, cramatory or other place)
Fort
Lincoln Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/29/2006 Brentwood, MD 21. Signature J Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis koad Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** pancreotic Concer unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မှ 2 ER/Outpatient 3□ DOA After the 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation death. 1 TYes 2 No 2 Accident t Director: d in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the h 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) DO041622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr Glen Burnie Md 21061 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	ate of Maryland	Depa <i>Cer</i>	irtment of H tificate of L	ealth and M D <i>eath</i>		en <b>2</b> 006	32970
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	<del></del>	3. Time of Death
	/Medic	al	Elizabeth  4a. Facility Name (If not institution, give stree	Arlene	Young	4b. City, Town, or	Location of Death	Septembe	er 28, 200	
	Examin	er	Potomac Valley Nursi			Rockvi			Montgom	
	Funeral Director		5. Social Security Number 018-18-1546 6. Sex 1 □ M	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 10,		thplace (State or Foreign puntry) A
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	a-fah	tor	Md. Montgomery	Gat	ithers	burg				1 Tyes 2 No
	with the	Dire	10e. Street and Number 10805 Eberhardt Dri	37.0		10f. Zip Code	20879-311		g. Citizen of What C United Sta	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	11. Marital Status	√as Decedent Ever in U.S rmed Forces? □ Yes 2 🕅 No	. 13. V	Vas Decedent of Hi Yes, specify Cubai			14. Race - Am Black, Whi	arican Indian,
	rat', or	by		Yes, Give ear or Dates:	1	☐ Yes 2∏ No	Specify:		Specify: W	nite
ה ה	n 72 h "natu adical	Completed	15. Decedent's Educatio (Specify only highest grade con	n npleted)	16a. Deced (Give i	lent's Usual Occupa kind of work done d DO NOT use retired;	ition furing most of work	ing	6b. Kind of Business	/Industry
7 7	d within	omo	Elementary/Secondary (0-12)	college (1-4or 5+)	House		<u> </u>		Own Home	2
משום	uid be filer fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) William John Bolton					e (First, Middle, Mi Louise Pa		
Mary	d 2 shouth and N 7 is man		19a. Informant's Name/Relationship (Type, F Cheryl Lee Morris (			g Address <i>(Street a</i> Garfield			City or Town, State, urg, Md.	
e,	s 1 and if Heali itsm 2 other		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place		Date 2	0c. Location - City or	
baltimor	ment comment of tent: if		1	val from State	erside	e, Cemete	ry 200	64,	Hancock,	ME
Da	permit Depar impor any in		21. Signature of Funeral Service Licensee	ay		Name and Addres  Description	DC	Vol Fune: Dr. Gaitl		Md. 20877
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused the death. use on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ongestive He	-	ailure				
	Examiner		Sequentially list conditions, b.	oronary Arte	ery Di	sease				
ī	led nsit	Examiner	n any, leading to immediate	entricular l		lation				
Ď	flicate be executed g physicien and as the burial-transit	Ехаг	that initiated events resulting in death) Last	Due to (or as a conseque						
56/50,	cate be physici the bu	edical	d. <u> </u>							In-
O. BOX 0	death certifi e ettending id for use as	hysiclan/Me	in the past 12 months?	yes, outcome of pregnan □Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Tas, T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contribu	ting to death but not resul	ting in the ur	nderlying cause give	en in Part I.			o the cause of death?
tecor	G S C1	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	sici <b>an:</b> The contificate he rector, page	e Co	25. Was case referred to medical				26 Place of Deat	1 Yes 2	X No 1 ☐ Ye	2 □ No
>	Physician: this certific al director,	ToB	examiner? 1 ☐ Yes 2 🎇 No	tal: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t_3□ DOA Othe			/ nce 6 ☐ Other (Spe	ocify)
ou o	iding Ph th. : After th : funeral		27. Manner of Death  1   Natural  2   Pending  2   Accident investigation	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	rat (? Yes 2 □ No	28d. Describe how	v injury occurred	
DIVISION	To the Hospital or Attending Physician: T within 24 hours effer death. To the Funeral Director: Affer this certificat completely filled in by the funeral director, px	ertification;	a Country 6 Could not be	Be. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	e Hospitt 124 hours is Funers letely fille	edicai C	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination						
	To the within To the compl	Me	29b. Signature and title of certifier	110		29c. License			d. Date signed (Mon	
ř	5		30. Name and address of person who comple			Print)	00512			1-2006
			Dr. Anushiraven Dadg	22 -Conjetende Signate			enter Dr.	#201 Ro	ckville, l	4d. 20850
	Sta Registi		OCT 0 3 2006	Algen B	Ans	ule				

State of Maryland / Department of Health and Mental Hygiene) 32971 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September Ž9, Elisina Young 2006 7:43 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10130 Old Frederick Rd. Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/25/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Months 1 M 2X F 103-38-4865 64 Colombia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2√ No Directo MD Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10130 Old Frederick Rd. 21042 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Hispanic 1 XYes 2 □ No Specify: Colombian 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cesar Sanchez Lucila Acosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10130 Old Frederick Rd. Ellicott City, MD Joseph Young/husband 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 10/2/2006 Catonsville, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01442 4112 Old Columbia Pk. Ellicott City, MD 21043 lerus Kadd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) zhermen's Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified W 020213 9/29/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Banks Mo Flags Day, Year) 32. Pegistrar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

0 3 2006

**Funeral** 

Director

ral, or items 23a or 28a-f ehow Examiner must be notified at

0.

"natural" or than "natura".

with the Maryland

death

filed within 72 hours after

s 1 and 2 should be filed within f Health and Mental Hygiene.

traumatic

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.

**Physician** /Medical

Examiner

and burial-tran

the attending physicien

the use as

ţō

detached

is been signed by the should be detached

page 2 certificate

funeral director,

the

filled in by

this

After

death.

within 24 hours after deatl To the Funeral Director:

the death certificate be executed

The law requires that

Attending Physician:

ō

To the Hospital

of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygien 2015 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician WILLIAMS 7:05PM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WES/EY BALHOUSE 14 Homas If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF 38 229 38 004s Usual Residence of Decedent Yrs. Director 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28e-f show the Modical Examiner must be notified at 1 Yes 2 No Director BALHAR MATYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21225 STACCH STOLL 953 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritaf Status permit. Pages 1 and 2 should be tiled within 72 hours after to Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or item any injury or other treumatic event, the Modical Exertina. Yes 2.25No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC JUnk 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAMS Arrington BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALSTON Sto11 , Mary Inno DAUghter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State MARYINO BALKNOR BALLINONE 4 ☐ Donation 5 ☐ Other (Specify) SIATIUN 36 Comiter, Nmc-21. Signature of Funeral Service Light see 22. Name and Address of Facility CHATMBR-HAMS Baltimore AN 21211 Kils Terstour Kuns arri 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metostatic COLOM **Physician** YROXS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Completed by Physician/Medical Examiner physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Noknown Cerebrouserian accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an estiva Heart autopsy performed? Yes 2 1 Yes 2 No After this certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Naturat 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 07930 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marvin J. Feldusan 227 Glock incco, gistrar's Signatur 31. Date filed (Month, Day, Year) State OCT 1 8 2006 Registrar

-			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artmen rtificate			and M		Reg. No.	200	16	329	
*	Physici	an	Decedent's Name (First, Middle, Last)  I avring a May	Aldon						2. Date of De Month	Day	7,	Year	3. Time of De 10:1:	
	/Medic		Levinia May  4a. Facility Name (If not institution, give s	Alder		4b. City,	Town, or	Location of		0ctobe	1	County o	2006 of Oeath	10.1.	J11
0.36	LXaiiiii	ĢI	15 Margaret Ave.				asad					Ann	e Arı	ındel	
	Funeral Director		213-30-9241		(In yrs. last birthday) 81 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan. 4	th y. Year) ,1925	5	9. Birthpla Countr Mary	ce (State or F Land	Foreign
	iand		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation							10	d. Inside City I	Limits
	Mary a-f eh	tor	Maryland N/A		Baltimo	ore								1 <b>☐ Ye</b> s 2	No
	or 28	Directo	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of Wi	hat Countr	y?	
	s 23s	ral	1619 Covington Stre					21230	-1-0 (0			J.S.A	A . · America	a facility	
	ours after death with the Marylan rel', or items 23s or 28s-f show Eversiner must be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ☐ Yes 2 ☐ K</li> </ol>	lo			n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	·   '		, White, et		
036	72 hours after death with the Maryland natural', or itams 23a or 28a-1 ehow dical Examinat musi be indiffed at		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2 110	Specify:				Specity:	Wh	ite	
2-0		Completed by	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ition luring mos	t of workii	ng	16b. Kin	d of Bus	iness/Indu	stry	
12	withie	dimo	Elementary/Secondary (0-12)	Coflege (1-4or 5 N/A	+)	omema.		,				Owi	n Hom	e	
d 2	m = 0 =	Be C	17. Father's Name (First, Middle, Last)	11, 12				18. Mothe	r's Name	(First, Middle,	Maiden :				
ylar		To E	Charles Ha	rold	Kline			Gra	ace	E1	izabe	eth	C	attert	on
Maryland 21215-0036	s 1 and 2 should Health and Mer Itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type	-						i Route Numbe				code)	
	1 and Healtl		Benjamin H. Alder,	Jr. (Sor	20b. Place of Dispo	sition (Nan	ne of			ena, Ma Pate			L L Z Z City or Tow	n, State	
I O	0 0		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Glen Have	matory or of en Men	n. Pl	9) C. :	10/21	1/06				Maryla	ind
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	е	Ma	2. Alame an	d Addres	s of Facilit	k Fui	neral H	ome.	P.A			
8	89558		John Fr A	llina						neral H Baltimo		aryla	and 2	1230	
A.	Physician /Medical Examiner	ner	23a. Part. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or ask	s):onsequence of):	e	٤	30	lei	mev	he		(	nterval Between Onset and Dea	en ath
. Box 68760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last	Bc. If yes, outcome of the control o	2 Fetaf death 3	]Ectopic pre					2	3d. Date Mont	of delivery	ay Yea	ar
P.0	et the de by the stached	hys	9 Unknown	9□ Unknown											
Records, I	w requires the been signed should be de	by	Part II. Other significant conditions con	6.1.	at not resulting in the u	nderlying ca	ause give	on in Part I.		23e. Did to	4			cause of dea	
al Reco	The ete h pege	Completed								24a. Was autop perio 1 🗆 Yes		pri de	ere autops lor to comp ath? Yes 2	y findings ava detion of caus No	aılabl <i>e</i> se of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			A Othe	-		(Check only o		/		Daly	4ta
of	of life	ıtlon: To	1 Yes 2 No  27. Manner of De th  1 Natural 5 Pending 2 Accident investigation	1 ∐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outpatier y 'Year) 28b. Time o Injury		8c. Injury Work	4 🗆 140	2	ne 5□Resio 28d. Describe h				Hown	C
Division	2 8 5 5	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injubulding, etc.	iry - At home, farm, st . (Specify)	reet, factory	, office		2	28f. Location (5 City or Tov		Number	r or Rural i	Route Numbe	or.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	(Check only 2 Medical Examir one)	ician: To the best of er: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred a vestigation,	at the tim in my op	e, date an	d place, a	and due to the ed at the time,	cause(s) a	and man	ner as stai	ed. ne cause(s)	
	withi To t	Σ	29b. Signature and the of certifier			29c	License	number	, 7		29d. Date	signed	(Month, Di	Hy Year)	20
	,0		000	nolated 1	ah (lia ii ca )	2	751	1991 1021	~	0 700	Octo	LACC	27	المالير	0
	0		30. Name and address of person who co					Bw		ie m	0 2	10	61		
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	<i>b</i>									

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Maryland / D	epartment of Health and N Certificate of Death	lental Hygien Reg. N	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic		EdWARD W	ES/54 15151	NOP	Oct 1	2 2006 9:00AM
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	4	c. County of Death
			36 20 6 HAGE  5. Social Security Number 6. Sex	7. Age (In yrs. last birth	ISALFI HELE  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director	}		14 OF 1	rs. Months Days Hours Min.	Month, Day, Yea.	1904 HAKYLAND
	pu 🍇		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Aaryla I ehov	ō	11 /		1/times 12		1 Des 2 □ No
	the 128a-	rect	10e. Street and Number	DA	10f. Zip Code	10g. C	Citizen of What Country?
	h with	io le	3620 Cutt Ag	E AUG	21215		USP
	me S	iner	TIT THAT GLASS	Was Decedent Ever in U.S.     Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Heelth and Mentel Hygiene. If em 27 ie marked other then "natural", or Iteme 23a or 28e-f ehow other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 27 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wack
21215-0036	2 hours	ted t	15. Decedent's Educ	ation 16a, I	Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	within 73 ene. then "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed)  College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	Re	ethlehen Steel
	e filed within al Hygiene. I other then '	Con	9	yems -	SHUP STEWARD		
Maryland	ntel H od otl	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	on Sumame)
Ž	should ind Men marke umatic	၉	19a. Informant's Name/Relationship (Typ	9 / 5 h 0 D 19b. 19b.	Mailing Address (Street and Number or Run		or Town, State, Zip Code)
Z	nd 2 salth ar 27 to r trau		CIARA BISKEP/	wift 36	20 Cettage Ave	Balton	m; Mel 2/2/5
J.e.	000	1.5	20a. Method of Disposition	cometen	Disposition (Name of v, crematory or other place)	1. /	Location - City or Town, State
<u><u><u></u></u></u>	Pages ment of ant: If its ury or o	. 3	4 Donation 5 Other (Specify)	DRUID	Ridge Coneky 10/	1011	LOW 1/E Mary Ins
Baltimore	permit. Page Department Important: Il eny injury o		21. Signature of Funeral Scarce Kinnse		22. Name and Address of Favity CLI		
ī			23a Party Enter the disease or complic	ations that caused the death. Do no	ot enter the mode of dying, such as cardiac	· ·	BALAMOR DLA ZIZIS
	Paratita		-shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Renal Failur		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence o		e	1 month
ı	Examiner		Sequentially list conditions b.				
	ק אָ	iner	if any leading to immediate	Due to (or as a consequence of	f).		
V	and and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	D:		
68760,	eath certificate be executed ettending physician and for use as the burial-transit	dical E			···		
		a a					
Вох	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
О. П	The law requires that the death certif ste hes been signed by tha ettending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□ Unknown	5 ☐ Other (specify)		MOILLI Day Teal
P.0.	wrequires thet the de been signed by tha should be detached		Part II. Other significant conditions conf	inbuting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Division of Vital Records,	tuires n sign ald be	d by	Sacral o	lecubitus u	ilær	1 ☐ Yes	2 No 3 Probably 4 ∭Unknown
Ö	s beer s shou	olete				24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed				autopsy performed2 1 ☐ Yes 2 ☑	
ital	ician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?			h (Check only one)	
<u>ح</u> د	hysic this ce	ဥ	1 ☐ Yes 2 No	ospital:			6 □Other (Specify)
uc.	Jing F	ion:	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
isi	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, far			and Number or Rural Route Number,
Ö	s efter of Dire	Certification:	4 Homicide determined	building, etc. (Specify)	,	City or Town, Sta	ite)
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funaral Director: Atter this certifica completely filled in by the funeral director, to	Medical (	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place, dor investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	othe othe omple	Mec	29b. Signature and title of certifier	and mannor stated.	29c. License number	29d. E	Date signed (Month, Dey, Year)
)	->F0		> Robert T.	Chow in	D D34851	0	ctober 16, 2006
	3		30. Name and address of person who could be 22, 2435 W	Belvedere 1	ive, Baltime	MD.	21215
	Sta Registi		31. Date filed (Month, Dey, Year) OCT 1 8 200	32. Egistrar's Signature	Sperk		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend item#1, perMD, G860, 10/18/06 TT Certificate of Death
Reg. No.4 1 - For State Registrar Reg. No.Z 1. Decedent's Name (First, Middle, Last) Edward Bogier, Jr. 2 Date of Death **Physician** 4.26 DM 2000 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Niversity of Maryland Med CTR If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours MM 2DF 66 NY Director 216-34-5199 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Heatth and Mental Hygiene. ont: If Item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow 10c. City. Town or Location 10a, Stale 10b. County 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6820 Old Pimlico Road 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Morgan State Elementary/Secondary (0-12) College (1-4or 5+) Finical Administration 12th grade University 8yrs+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Bogier Alberta Boyd ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6820 Old Pimlico Road, Baltimore, Md 21209 Gloria Bogier-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment o importent: If eny injury or once. ŏ Lakeview 4 ☐ Donation 5 ☐ Other (Specify) 10/14/06 Sykesville, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximale Interval Between Onset and Death Immediate Cause (Final Subarach no Dhemonhuge, Intraverebra? Physician disease or condition resulting in death) /Medical nemorrogo. Due to (or as a consequence of) Examiner DRUMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed the burial-transit ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: -23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed peen s 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 EP/Outpatienl 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠ No ို this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending nours efter death.
nerel Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Geriffee Medical completely. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23a) (Type, Print) Name and ad . Fullmore, MD 2120 syeene Si

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1- For Amend item#31, perDVR, g860, 10/18/06 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Christian 14, Louise Bernice Bradley October 2006 8:35pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Director 213-32-4846 03 11 39 MD Usual Residence of Decedent death with the Maryland a or 28a-f show t be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No **Funeral Director** MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ns 23a o 3918 Park Heights Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or iten idical Examiner filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade College (1-4or 5+) 2yrs Nursing Assistant Hospitals 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ John A. Christian Nancy Pryor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mardina Boykins-Daughter 6716 Meekins Ave, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State King Memorial Park 10/23/2006 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 of Funeral Service Licensee 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dm /Medical Due to (or as a consequence of): Examiner NO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner be executed ESRD attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. CAD The law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9□Unknown 9 Unknown þ s been signed by should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 2 s certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 221√0 P 1 🗌 Yes 1 Hipatient 2 ER/Outpatient 3 DOA di this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

Division or Vital Hospital or Attending Physician: n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur within 2

> State Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of pentify

31. Date filed (Month, Day, Year, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200₺

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

WILHEMINA BOEHM

			_ For	Please 1	Type or Prin						•		_	32	977
		•	1 - State Registrar				Ce	ertifica	te of	Death		Reg. N		O L	711
	District.		1. Decedent's Nam	e (First, Middle, Last	)						2. Date of De		ay Year	3. Time	of Death
4	Physicia /Medic		WILKELMI	NA BOEHM									16 2006	7:	15AM <sup>™</sup>
	Examin			If not institution, give				4b. Cit		r Location of Dea	ath	4	c. County of Death	1	
				lar Hill [		- (1-	to an in teste of a	) If I Ind	Ann er 1 Year	apolis	*		nne Arun		
	Funeral		5. Social Security N	10	TAL OFF		la <i>st birthday</i> Yrs.	Months		Hours Mir	. (Month, D.	ay, Yea	r) Coi	intry)	e or Foreign
	Director		213-14-2 Usual Residence of			103					Oct. 3	30,	1902 Ma:	rylan	J
	yland		10a. State	10b. County		10c. Cit	y, Town or L	ocation						10d. Inside	City Limits
	a-fel	to	Maryland	Anne Arur	ndel			Ar	napo	lis				1 🗆 Y	es 2 X No
	or 28	ire	10e. Street and Nu	mber				10f. Z	ip Code			10g. C	itizen of What Co	untry?	
	s filed within 72 hours after death with the Maryland. I. Hygiene. other than "nature!!, or iteme 29a or 28a-f ehow. ent, the Madical Examiner must be notified at	Funeral Directo	1341 Pop	lar Hill [	)rive				214				USA		
	ar de	une	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	. Was Dec If Yes, sp	edent of F ecify Cubi	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Narto Rican, etc.)	0-	14. Race - Amer Black, White		,
20	rs aft	by F	1 ☐ Never Marr	ied 2 Married	1 ☐ Yes 2 <b>反</b> I If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>X</b> No	Specify:			Specify: Whi	ite	
2-003d	hou		XX	15. Decedent's Edu			16a. Dece	edent's Us	ual Occur	pation		16b.	Kind of Business/l	ndustry	
2	nin 72	Completed	(Spec	cify only highest grad	le completed) College (1-4or !		(Giv	e kind of w DO NOT	ork done use retire	during most of w	orkin <b>g</b>			,	
7	d with	E O	12 yrs.	ondary (0-12)	N/A	o+)	Sec	retar	'n			Be	thlehem :	Steel	Corp.
2	e file al Hy othe	Bec		(First, Middle, Last)						18. Mother's Na	ame (First, Middle	, Maide	n Sumame)		
yland	should be nd Mental marked c	Tof	William	Haapman						Doroth	ea Tront	rup			
- T	and and in man			ame/Relationship (7)			1	-				_	or Town, State, Z		
2 '`	and leelth m 27 her ti			B. Conti	(Daughter)	The second second	the second second	The second second			Annapoli		Md. 2140: Location - City or 1		
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Depermitment of Heelih and Mental Hygiene. Deperment of Heelih and Mental Hygiene. Important: If them 27 is marked other than "natural; or iteme 29a or 28a-1 show eny injury or other treumatic event, the Madical Examiner must be notified at once.			□Cremation 3 □F		1	lace of Disp emetery, cre			1					
аппо	rtmer rtent njury			5 ☐ Other (Specify) Service Licens		Par	kwood		4		9=2006	Ва	ltimore,	Md.	
מ	Depermine of the property is a property in the property in the property in the property is a property in the p		21. Signature of Ft	Service Liceris				Lassa	hn F	uneraĺ ⊦	lome				
			23a, Part I, Enter t	the disease, or comp	lications that caused	d the deat							d. 21236	Approxir	nate
١,			shock, or hea Immediate Cause	art failure. List only o	ne cause on each li	ne.	0	0	_	-					nd Death
	mysician /Medical		disease or condition resulting in death)	on	a Due to (or as	a conseq	uence of):	ax		-WT	encys	500	-	MINI	143
	Examiner			- 1			30.130 31,1								
Ţ		ner	Sequentially list co if any, leading to in	enditions, nmediate	Due to (or as	a conseq	uence of):								
V	e executed ien and urial-transit	Examiner	Cause (Disease or that initiated events	S 🔳	c										
	~ 0 =	-	resulting in death)	Last	Due to (or as	a conseq	uence of):								
	feath certificate be ex ettending physicien I for use as the buria	lan/Medica			d										
_	certificate nding physise as the	/Me	IF FEMALE:		23c. If yes, outcome	of pregna	incv						20d Data of dali		
X D D	death of etten	ian	23b. Was deceden	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	☐Ectopic		У			23d. Date of deli Month	Day	Year
j.	0 0 2	Physicia	1 ☐ Yes 2 9 ☐ Unknown	No	9□ Unknown			_ 0(	spoony/						
7	requires that the veen signed by th hould be detache	by Pł	Part II. Other signi	ficant conditions co	ntributing to death b	out not res	ulting in the	underlying	cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause	of death?
ecords,	w require been sig should b			<u></u>							1.0	Yes	2 <mark>X</mark> No 3□Pro	bably 4	∐Unknown
ပ္သ	> 11 0	plet									24a. Wa:		24b. Were au	topsy findin	gs available
Ĭ	о <u>г</u> о	Completed						-			auto perf	ormed?	death?	ompletion o 2 ☐ No	or cause or
	ysician: Th	Be C	25. Was case reference	rred to medical						26. Place of D	eath (Check only				
<b>&gt;</b>	S S	2	1 □ Yes 2⊅	ΓNο I	Hospital: 1 🗌 Inpatio	ent 2 🗆	ER/Outpatie	ent 3 🗆 🛭	NA .	ner: 4 ☐ Nursing	Home 5 Res	idence	6 ☐Other (Spec	ify)	
	ding Phys n. After this funeral di	 	27. Manner of Death	th 5 🗌 Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time Injury		28c. Injui Wor		28d. Describe	how inj	ury occurred		
IVISION	Attending ir death. ector: Aftei by the fune	cat	2 Accident	investigation 6 Could not be	CO. Plan dis			M		Yes 2□No	206 Leaghing	/C+		1.00 1	
$\mathbf{\xi}$	or Al	Certification:	4  Homicide	determined	28e. Place of Inj building, et	ic. (Specif	y)	treet, fact	ory, office		City or To	wn, Sta	and Number or Ru te)	rai Houle N	umper,
_	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Lifector: Alter th completely filled in by the funeral	CE	29a. Certifier	1 Contilying Phy	sician: To the best	of my kno	wiedoa Jar	ith occurr	d at the ti	me data and play	na and due to the	causal	s) and warner as	stated	
	the Ho hin 24 h the Fu npletely	edical	(Check only one)	2 Medical Exam	iner: On the basis o and manner st	f examina	tion and/or i	nvestigation	on, in my o	ppinion, death oc	curred at the time	date a	nd place, and due	to the caus	e(s)
	Vithii To the	ž	29b. Signature and	Title of certifier				2	9c. Licens	se number	,	29d. D	ate signed (Month	, Day, Yea	)
			197	wien		WL	>		L	1696	-/	(	0-16-	200	06
	a		30, hams and add	(1)	ompleted bauts of o	neut) meac	0	CZ.	X	14.	Λ.		10 11.	2	1012
	l cr	•	31. Date filed (Mor	- > - ( )	AAC 32. Registr	rar's Signa	iture's	100	e	ne	L VAN,	0	in, m	7/	1012
	Sta Registr			111111111111111111111111111111111111111	UUO A	660	15 1		Cost of		t .				

State of Maryland / Department of Health and Mental Hygien 9 0 6 32978 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harold D. Bierlev /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day Yes April 27, 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1935 South Carolina 1**™** M 2□ F 71 Director 213 32 6068 Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location th and Mental Hygiene. 27 is marked other then "naturel", or Iteme 23a or 28e-f ehow traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo Marvland Anne Arundel 1 ☐ Yes 2 No Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 905 Church Street U.S. 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 囟 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 200 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 8th Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Manual Bierley Cecil Tague ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Jordan / sister 5304 Patrick Henry Drive Baltimore, Maryland 21225 f Health ( 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it eny injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pmr1. Enter the disease or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Obstru /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sicien and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical anding physics use as the ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death P.O. I 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes l director, page 2 s autopsy performer Yes 2 1 ☐ Yes 2 ☐ No 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 1 Tes 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death
CNatural
Accident Date of Injury (Month, Day 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the fo 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) of or A 4 ☐ Homicide Hospitel To the Hospitel
within 24 hours e
To the Funarel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43977 October 12 2006. we, Wen Burne. Ms. 21061. MM) death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2006 Registrar 8

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	_			_			_	
2	0	U	6	3	2	9	7	(

		1- For State Registrar		Certi	ificate of	Death			Reg. No.	00 3291
Physic	ian/	Decedent's Name (First, Midd	de,Last)					2. Date of De	eath	3. Time of Death
dical Exam		RAYMOND BRO	WN					Month October	Day Year 13, 2006	0320 hrs
		4a. Facility Name (if not institution		mber)	14	4b. City, Town, o	r Location of D		4c. County of [	Death
		Prince Georges Hosp				Cheverly			Prince Ge	
Funeral		Social Security Number	6. Sex	7. Age (In yrs. las	t birthdav)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of F	Birth (MM/DD/YYYY)	· ·
Director						Months Day		Min.	F	oreign Wash
		231-37-1388	1 X M 2 F	36	Yrs.			3/6/	1970	Country)D.C.
'n.		Usual Residence of Decedent  10a. State  10b. County		10a City T	own or Locati					14011
w any		Toa. State		Too. City, 1	own or Locati	OII				10d Inside City Limits
and f sho	5	Md. Princ	e George	La	rgo					1X Yes 2 No
//ary 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
the la or	一喜	630 Stillwat	er Place			2072	1		USA	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	la la	11. Marital Status	12. Was Dec	edent Ever in U.S.		s Decedent of H	spanic Origin?	? ( Specify Yes or N		American Indian, Black,
leath r iter	Funeral	1 Never Married 2 X	Armed Fo	rces?	If Yo	es, specify Cuba	n, Mexican, Pu	uerto Rican, etc.)	White, e	etc.
fter of	I E	3 Widowed 4 Di	vorced If Yes, Give Yea		1	Yes 2X No	specify:		Specify: B	lack l
5-0036 Iled within 72 hours after Hygiene I other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	ecify only highest grad	e completed) 1		t's Usual Occupa			16b. Kind of Busin	
72 ho	ompleted	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during me	ost of working life	e. DO NOT use	e retired)	-	
336 thin he than	[ 후	12		M	lusic	Engine	or		Music	
5-0036 Iled within 7 Hygiene I other than	S	17. Father's Name (First, Middle	e, Last)	F42	ubic	DIIGINO	18.Mother's N	Name (First, Middle	, Maiden Surname)	
215 be file ntal H rked o	Be (	Gerald L. Br	own				Lind	a Brown		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 17: Tis market other than "natural", or items 23a or 28a-f she ratic event, the Medical Examinor must be notified at once	100	19a. Informant's Name/Relations		77	19b. Mailing	Address (Stre	et and Number	r or Rural Route N	umber, City or Town,	State, Zip Code)
MD d 2 sho lth and n 27 is numati		Danielle Bro	wn	-					rgo, Md.	
imore, MD 21215-( Pages I and 2 should be filed ment of Health and Mental Hyg tant: If item 27 is marked out or other traumatic event, the		20a. Method of Disposition			ace of Disposi	ition (Name of ce		Date	20c. Location - Ci	
Ore ges I t of I		1 X Burial 2 Crematio	n 3 Removal fro	iii Otate	ematory or oth					
ti Pa tmen rtant	H	4 Donation 5 Other S		Ced		11 Cem	. 10	0/20/20	06Brookl	y Park, Md
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		21. Sign of Funeral Service	Licens	de	主	tep_Br	other	s Funer	alServic timore,M	e,P.A.
		23a. Part I. Enter the disease, o	111.6		$1^{-13}$	00 Eut	aw PI	ace,Bal	timore, M	
Physician Medical/		failure. List only one cause	e on each line.	iuseu ine ream. L	of lot enter tr	ie mode or dying	, such as card	liac or respiratory a	rrest, snock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease		ound of Ches						Death
		or condition resulting in death)	Due to (or as a	consequence of):						
	<u>.</u>	Sequentially fist conditions, if any, leading to immediate	Due to (or as a	consequence of):						
	įį	cause. Enter Underlying Cause (Disease or injury that initiated								
- W	Examiner	events resulting in death) Last	Due to (or as a	consequence of):						7.1
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	a E		d							
), be ex ician urial	n/Medical	UNPENDED	AMENDED							
68760, certificate bo nding physic se as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in t	ho	outcome of pregna					23d. Date of de	livery
68 certif	ian	past 12 months?	I LIVE D	rth ant at time of deat	h		Ectopic pro	regnancy	Month	Day <b>Ye</b> ar
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Un	iknown g Unkno		n 5 Oth	ner (Specify)				
the d	P.	Part II. Other significant condi		death but not res	ulting in the u	nderlying cause	given in Part I	23e Did	tobacco use contribut	te to the cause of death?
P.O. es that the general by the detach	٤		•			,	g			Probably 4 Unknown
S, quire en sis	Completed									
OFC IW re as be	B B							auto	opsy prio	re autopsy findings available r to completion of cause of
Rec The li sate h	E							pen 1 ✓ Yes	formed? dear 2 No 1	th? Yes 2 No
at F	C	25. Was case referred to medica		-		26.Plac	e of Death (Ch	neck only one)		-
of Vital Records, ag Physician: The law requirements certificate has been someral director, page 2 should the	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2 🗸 E	R/Outpatient	3 DOA	Other <sub>4</sub> N	lursing Home 5	Residence 6 (	Other:
of ig Ph	=	27. Manner of Death	28a. Date Oct 13,	of Injury 2	8b. Time of Ir	njury 28c. Inju	ury at Work?		e how injury occurred	
	ģ		anig .	2006 (	0231 hrs	1	Yes 2 🗸 No	Subject sh	ot	
iSical Particular de la contraction de la contra	ig		estigation	of Injury - At hom	ne, farm, stree	et, factory, office	building, etc.	28f Location	(Street and Number of	or Rural Route Number, City
Division tal or Attendi rs after death al Director: A	ertification:		old not be (Specify)	Local Street				or Town,		
fospi 4 hou funer ely fil	1 13	20a Cartifica	hysician: To the bes			red at the time of	late and place			
	2	Certifying P							e and place, and due	
the the	dical 0	(Check only   Certifying P								
Division of Vital   To the Hospital or Attending Physician: within 24 hours late death To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only   Certifying P	and manner st			29c. Licen	se number	<del></del>	29d. Date signed	
To the within 2 To the complet	Medical C	one) 2 Medical Exa	and manner st				se number		1	(Month, Day, Year)
	Medical C	(Check only one) 2 Medical Exc.  29b. Signature and title of certification of the control of the control of the certification of the ce	and manner st	ated	20)				29d. Date signed October 13, 2	(Month, Day, Year)
To the within To the complet	Medical C	(Check only 2 Medical Example)  29b. Signature and title of certification.  30. Name and address of person	and manner si	e of death (Item 2	,	O.C	M.E.	MD 21201	1	(Month, Day, Year)
12	Medical C	(Check only one) 2 ✓ Medical Example 29b. Signature and title of certification of the signature and address of person Melissa Brassell, MD	and manner ster  augustus  n who completed caus  Assistant Mer	e of death (Item 2	r 111 P		M.E.	MD 21201	1	(Month, Day, Year)

1 - State of Maryland / Department of Health and Mental Hygien 0 6

State of Maryland / Department of Health and Mental Hygien 0 6

Registrar Registrar 1 - State of Maryland / Department of Health and Mental Hygien 0 6 32980 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year **Agnes Bruce** 3: 45P M OCT 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lutherville **Baltimore Brightwood Center** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 8, 1908 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X**☐ F New Jersey Director 98 Yrs Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Exempler must be notified at **Baltimore** 1 Yes 2 No N/A Director Marvland 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 2; any injury or other traumatic event, the Medical Ferroll MAGE. 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1040 Deer Ridge Drive 21210 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Moore Armand Guicheteau ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Deer Ridge Drive Baltimore, Maryland 21210 Robert Bruce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/06 Catonsville, Maryland 5 ☐ Other (Specify) Metro Crematory, Inc. 4 Donation 21. Signature of Huneral Service Licensee, 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 complications that caused the death. Peak Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. to not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of) Examiner FAILURE THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). use as the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 ☐ No director, 25. Was case reterred to medical examiner?
1 \( \text{Yes} \) 2 \( \text{No} \) No To Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred \*Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spuple ND DO053150 007 13 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Lantago Shalun male este 31. Date filed (Month, Day, Year) 32 Registrar's Signature State GENERALIA . 2006 Registrar 8

6-07584	~	h. Olaha				k Indelible Ink			
ewis Edward Boa		1- For State	-	•	ent of Hea ate of Dea	ith and Mental I		200	6 3298
Physiciar		Registrar  1. Decedent's Name (First, Middle,Last)				ardley Jr.	2. Date of Dea	ath	3. Time of Death
		<del>Louis E. Board</del>	ley, Jr.		wis E. Box		October 8	Day Year 3, 2006	1055 hrs
		4a. Facility Name (if not institution, give 1635 East Coldspring Lane			-	Town, or Location of Dea	th	4c. County of Dea	ath
Funeral	-	Social Security Number 6. Sex	7. Age (In	yrs. last birth	nday) If Un	der 1 Year If Under 24H	rs. 8. Date of Bi	rth (MM/DD/YYYY) 9. I	
Director		216-54-5099 1X	M 2 F	57	Yrs. Mont	ths Days Hours M	in. 10/11		eign Country) VA
any	F	Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town	or Location				10d Inside City Limits
*	اءِ	MD N/A		Balti	more				1 XYes 2 No
Maryland 28a-f show d at once.	웋	10e. Street and Number				p Code		10g. Citizen of What Co	ountry?
with the Maryland ns 23a or 28a-f sho be notified at once	ā	1635 Cold Sprin	g Lane		2	21218		USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If tiem 27 is marked other than "natural", or items 23a or 28a-f should the transmatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1 Never Married 2 XXMarried	12. Was Decedent Eve Armed Forces?			dent of Hispanic Origin? ( orfy Cuban, Mexican, Puer		14. Race - Am White, etc.	erican Indian, Black,
fter death			If Yes, Give Year	No	1 Yes	2X No specify:		Specify: B1	ack
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene rt: filem 27 is marked other than "natural other traumatie event, the Medical Examin	g p	15. Decedent's Education (Specify onl	or Dates: y highest grade complet			Il Occupation (Give kind o		16b. Kind of Busines	
56 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				stiled)		-
d withi	틹	12   17. Father's Name (First, Middle, Last)		סמן	mestic	Engineer  18.Mother's Nar	ne (First, Middle,	Self Em	ployed
21215-0036 Uld be filed within 7 Mental Hygiene event, the Medica	. 1	Louis E. Boardl	ev, Sr.			Mae Al	ice Huc	lnall	
221 hould I hould I is man	င္	19a. Informant's Name/Relationship (Ty	pe, Print )			ss (Street and Number of			
MD and 2 sho salth and 2 set 27 is raumati	1	Joyce A. Brown  20a. Method of Disposition		20b Place o	35 E.C	old Sprin	g Ln.,E	Baltimore 20c. Location - City	, Md. 21218
Baltimore, permit Pages I an Department of Hea Important: If itee injury or other tra		1 XBurial 2 Cremation 3	Removal from State	cremato	ory or other place			1	
Baltimore permit Pages I Department of F Important: If i	+	4 Donation 5 Other Specify: 21 Ston ture of Funeral Services License		AIDUU		d Address of Facility	/10/200	pbartino	re, Ma.
Department of the property of	1	Thomas III. S	-S/0/A		Estep 1308	Brothers Eutaw Pla	Funera	l Servic	e, P <sub>1</sub> A <sub>17</sub>
Physician	1	Zsa. Part I. Exter the disease, or complifailure ust only one cause on each	cations that dailsed the	death. Do no	t enter the mode	of dying, such as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	ì	The state of the s	Intracerebral		hage				Death
		,	ue to (or as a conseque	nce of):					
	ner	Sequentially list conditions,	oue to (or as a conseque	nce of):					
4	Examiner	(Disease or injury that initiated C. =	Due to (or as a conseque	nce of):					-
ecuted and transit	<u></u> L	d			1	060	1 0/ 07		
O, be excessician sician	g				perMe, g	<b>xer me g863</b> 862, 12/5/06 T	1-24-0/ [	vt	
Box 68760, e death certificate be exe the attending physician and for use as the burial -	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth	f pregnancy 2	Fetal death	n 3 Ectopic preg	nancy	23d. Date of deliv Month	ery Day <b>Y</b> ear
eath cert	sicia	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time			ecify)			
b. BC the dea	ڇَ	Part II. Other significant conditions	9 Unknown	not resulting	in the underlyin	ng cause given in Part I.	23e. Did 1	obacco use contribute	to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death  "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	হ	Chronic drug us			,,	· · · · · · · · · · · · · · · · · · ·			obably 4 🗸 Unknown
rds, requir been s	Completed					•	24a. Was		autopsy findings available completion of cause of
eco he law te has	E I						perfo	ormed? death	·
tal Rec	e B	25. Was case referred to medical				26.Place of Death (Chec			
Vit.		1 ✓ Yes 2 No	ospital: 1 Inpatient				sing Home 5	Residence 6 🗸 Ott	ner Scene
Sion of Attending Phreetor: After by the funeral	ö	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. 1	Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
Atten Atten rector by the	icati	2 Accident Investigation	28e Place of Injury	- At home, fa	rm. street. factor	ry, office building, etc.	28f Location (	Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, within 24 hours after death Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To	3 Suicide 6 Could not be determined	e			, , , , , , , , , , , , , , , , , , , ,	or Town,		
Hosp 24 hou Frunce etely fi		29a. Certifier 1 Certifying Physicia				ne time, date and place, a			
To the Howithin 24 F	Medical		On the basis of examina and manner stated.	ition and/or ir			d at the time, date		
1.	≥	29b. Signature and title of certifier	2001		29	9c. License number  O.C.M.E.		29d Date signed (A	
KING		30. Name and address of person who c	ompleted cause of dooth	(Item 23a)		O.O.IVI.L.		October 9, 200	
100	- 11	Co. Haine and address of person who c	ompressa cause or uedit	( ( ( COII 200)					

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32 Registrar's Signature

State Registrar

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 32982 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October James E. Brown 2006 1:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 6, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Va . Funeral 1 M 2 □ F 230-09-4549 89 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 Yes 2 No Director MD N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 E. Belvedere Ave. 21239 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 72 /22 /43 ive 4 / 18 / 43 1 ∏ Yes 2 ☐ If **X**es, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black Specify: þ 3 X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone. Staff Sgt. U.S. Corp. Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Brown Ethel (Surname Unknown) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Noonan/Caregiver 1110 E. Belvedere Ave., Baltimore, Md. 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 10/18/2006 Baltimore, Md. 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician inchibanc Cancer of disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Mnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy perform 2 **N**No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

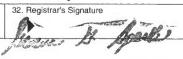
To the Funeral Director: A completely filled in by the fu

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

(Check only

29b. Signature and title of certifier



**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ST

29d. Date signed (Month, Day, Year) October 16 2006

		1 - For State Registrar	tate of Maryland / D	epartment of H Certificate of L	ealth and Me Death	ntal Hygiene		32983
Physici /Medic		1. Decedent's Name (First, Middle, Last) $Alice  D$	elores Burre	e11		Date of Death Month Da	12 2006	3. Time of Death
Examir			Baltimore	Baltim	Location of Death	40	N/A	
Funeral Director		214-20-0200	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min. 8	Date of Birth (Month, Day, Year) JUL 27,	9. Birthp	lace (State or Foreign
ehow	or.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town				11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
rith the M or 28a-1	Director	MD Baltimore  10e. Street and Number	Gwynn	10f. Zip Code		10g. Cit	tizen of What Coun	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland ind other than "natural; or items 23s or 28s-f show do other than "natural; or items 23s or 28s-f show event, I'm Medical Examinar must be incitied at	Funerai		Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No		n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White, e	
72 hours a	eted by	3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade cc	mpleted)	1 ☐ Yes 2 No  Decedent's Usual Occupa (Give kind of work done of	luring most of working	16b. K	Specify: Bla  Kind of Business/Ind	
permit. Pages 1 and 2 should be filed within 7 bearant of the filed mand Mental Hyglene. Important: if item 27 is marked other than "n any injury or other traumatic event, Ita Medigne.	Completed	Elementary/Secondary (0-12) 11  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	iiie. DO NOT use retired ycare Provic	)	Da	aycare	
nould be to Mental Inarked of	To Be	Harry Carter			Mary Jo	ones		
and 2 st leelth and m 27 ie n her traun		19a. Informant's Name/Relationship (Туре, Edward N. Burre11/)	nusband 41	Mailing Address (Street a	l Ave. Gwyr	nn Oak, MI	21207	
Pages 1 ment of H ant: if ite ury or oti		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ Remarks ☐ Donation 5 ☐ Other (Specify)	oval from State cemetery	Disposition (Name of c, crematory or other place Crematory, I			ocation - City or To	
permit. Departe Import any inj		21. Signature of Funeral Service Licensee	. Todd Dring	Cremation S 299 Frederi	s of Facility OCIETY of ck Rd Balt	Maryland,	Inc.	
Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only ene commendate Cause (Final disease or condition resulting in death)	ons that caused the death. Do no ause on each line.  Sep 5 i 5  Due to (of as a consequence of	ot enter the mode of dying	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of					
icate be executed physicien and the burial-transit	dical Exar	that initiated events c c d d d d d d	Due to (or as a consequence of	f):				
The faw requires that the death certificate is the faw requires that the death certificate hes been signed by the attending pipage 2 should be detached for use as the factor of the factor is the fac	Physician/Med	in the past 12 menths?	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ry Day Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions contrib Sub arachner Jh	uting to death but not resulting in	the underlying cause give	n in Part I.	23e. Did tobacco t	use contribute to the	,
The law requeste hes been page 2 should	Completed	Diabetes mellit	us			24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 xInpatient 2 ☐ ER/Outp	patient 3 DOA Othe	26. Place of Death (		- 500 40	
To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifical completely filled in by the funeral director;	⊢ ,	27. Manner of Death  1 Manual 5 □ Pending 2 □ Accident investigation	8a. Date of Injury 28b. Ti	me of 28c. Injury		5 ☐ Residence		)
tal or Atters efter de al Directe ed in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office	28	Location (Street and City or Town, State		Route Number,
the Hospi in 24 hou the Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Cartifying Physicia 2 Medical Examiner:	in: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the tim for investigation, in my op	e, date and place, and inion, death occurred	d due to the cause(s) at the time, date and	) and manner as sta d place, and due to	ated. the cause(s)
To T To T	Σ	29b. Signature and title of certifier		29c. License	number	29d. Da	te signed (Month, L	Jay, Year)
10		30. Name and a dress of person who compl	C .	Type, Print)	-000	Oct	Ober 17	4,2006
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature,	Goerce Hosp	ital et	Saltin-	ore	
Registr	ar	OCT 1 8 2006	proceed of the	1				

State of Maryland / Department of Health and Mental Hygien 200632984 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** HENRY HERBERT BELL OCT 2006 /Medical 16 4:21 Α 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr. 30, 1 **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1**∑** M 2□ F Min Yrs. Director 042-22-9462 78 1928 Connecticut Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 28e-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylai ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or Itams 23a or 28e-f shov ury or other traumatic event, the Medical Exacts or trait to invitted at Director 1 ☐ Yes 2 ₩ No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 8205 Fenway Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

IX Yes 2 □ No 1946
If Yes, Give Year or Dates: 1986 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1947-Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: 1989 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Rear Admira] Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Clinton H. Bell Ruth Blaisdell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda B. Bell/Wife 8205 Fenway Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Arlington National permit. Pages Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 200/
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Arlin ton, Vir∘inia 21. Signatur Transes MO0803 Bethesda-Chevy Chase, Inc.

Bethesda, MD 20814-3501

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed ng physicien and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter for u 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 XYes 2 □ No Director: After this certific of in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 ☐ Yes 2 🟋 No 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 12 M 0101238561 (VA) 0+ 30. Name and address person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MARK D. JOHNSON LT MC USN EETHESDA MD 20889-5600 32. Registrar's Signature 8 2006 State Registrar

32985

			1 - State Ragistrar	ertificate of Death	Rag. f	No.
	Physici		Decedent's Name (First, Middle, Last)     ALBERT B. CARY, SR.		2. Date of Death Month OCT . 1	Day Year 2, 2006 9:15P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) FUTURECARE IRVINGTON	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death  N/A
	Funeral Director		5. Social Security Number 223-24-2438 6. Sex 1 1 2 F 82 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yea 03/05/1	
	death with the Maryland me 23s or 28s-f ehow rmust be notified at	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or	Cocation TIMORE CITY		10d. Inside City Limits  Y Yes 2 □ No
	r death with the Marylar eme 23a or 28a-f ehow er must be collified at	al Director	10e. Street and Number 4505 PENHURST AVENUE	10f. Zip Code 21 21 5	10g. (	Citizen of What Country? USA
2-003p	or its	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? Korea  1 Never Married 2 Married  15 Yes, Give Year or Dates: Army	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2☐MNo Specify:</li> </ol>	Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK
-61212	d within 72 hours plene. r then "netural", the Medical Exe	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired) SEL MECHANIC	cc CC	. Kind of Business/Industry ONSOLIDATED NGINEERING CO.
land	uld be filed fental Hyg rked othe ilc event,	To Be C	17. Father's Name (First, Middle, Last) ALBERT B. CARY		e (First, Middle, Maid E WRIGHT	'en Surname)
Mary	alth and National Nat		19a. Informant's Name/Relationship (Type, Print)  ALBERT B. CARY, JR. / SON 47	ailing Address (Street and Number or Rur 7 LINCOLN DRIVE	al Route Number, City , GLEN BU	y or Town, State, Zip Code) JRNIE, MD 21060
more,	Pages t and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition  1 X Xurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition  20b. Place of Disposition  ARBUT  PARK	sposition (Name of constant National AL 10/	Date 20c.	Location · City or Town, State  BALTIMORE CO., MD
Dail	permit. Departn Imports any Inju		21. Signature of upleral Service Licensee	22. Name and Address of Facility HO 4600 LIBERTY HI	OWELL FUN EIGHTS AV	NERAL HOME 21207 VE, BALTIMORE, MI
68760,	by Strifticate be executed ing physician and ing physician and as the burial-transit	Medical Examiner	23a. Fight. Enter the decase, or complications that caused the conth. Do not stock, or heart dilure. List only one cause on each line.  Immediate Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	- of hightle	rosis	Approximate Interval Between Onset and Death
C. BOX	ath ce attendi for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ras, r	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown
Hecord	The lav ate has page 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vital H	Physicien: r this certificated director.	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Deat	h (Check only one)	
ō	2 = 0	2	1 ☐ Yes 2 ⚠ No	tient 3 DOA 4 Nursing Ho	me 5 Residence	6 □Other (Specify)
0	ding Ph th. : After th s funeral	tlor	t Natural 5 ☐ Pending (Month, Ďaý Year) Injul 2 ☐ Accident investigation			,-,
DIVISION	al or Atter after dea I Director d in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Privilin 24 hours after death. To the Zuneral Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one)  Cartifying Physician: To the best of my knowledge, drawn one)  Cartifying Physician: To the best of my knowledge, drawn one)  Cartifying Physician: To the best of my knowledge, drawn one)	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	Total	Ň	29b. Signature and title of certifier  Wald Sopry MD	29c. License number	29d. [	Date signed (Month, Day, Year)  O 13 2006
7	)		30. Name and address of person who completed cause of death (Item 23a) (Tyl NISHA P-SOPRE/M) 3300	Dood4476 Garrison Blod	Baltin	mon MD
	Sta	ite	31. Date filed (Month, Day, Year) 32. Palistrar's Signature			

DHMH 17 Rev 1/2001

Registrar

OCT 1 8 2006

State of Maryland / Department of Health and Mental Hygien2005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Childress 5 4 1 2006 Oct 12, 6:16 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital 8. Date of Birth (Month, Day, ) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 94 Frackville, PA Director 162 07 9067 Usuel Residence of Decedent 10c. City, Town or Location Item 27 is marked other then "natural", or iteme 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Prince George's Forestville 1 ☐Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 Shelton Place 20747 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 📉 o Specify: δ Specify: White 3√ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other then "n! any injury or other treumatic event, the Medic 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Car dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kita Martin Kozac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Childress (Son) One Plantation Court, Oceanview, DE 19970 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)Oct 18, 2006 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature Alexandria Ferry Rd, Clinton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Phyeician: The law requires that the death certificate be executed rettending physicien and for use as the burial-tran-Due to (or as Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death signed by the e 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 12 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA After thi 27. Mangfer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -2453 10,12,06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa, M.D. 7700 Old Branch Ave, Suite 101, Clinton, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 8 2006

32. Registrar's Signature

06-07704 Gary Crisp, Jr.

# Please Type or Print in Black Indelible Ink

2006 32987

		State of Maryland / -For State amend #5 Per Fi Registrar	* Certificate of	Death	R	eg. No	
Physician dical Examine	1/	1. Decedent's Name (First, Middle,Last)  Garry Crisp, II			2. Date of Dea Month October 1	th Day Year	3 Time of Death 1812 hrs
A. C. C. C. C. C. C. C. C. C. C. C. C. C.	ľ	4a. Facility Name (if not institution, give street and number) 6803 Dunnigan Drive	4	b. City, Town, or Location o		4c. County of Death	
Funeral Director		21/ 12 2006	(In yrs. last birthday) 20 Yrs.	If Under 1 Year If Under Months Days Hours	Min.	th(MM/DD/YYYY) 9. Bir Foreig	
Jaryland 28a-f show any Lat once,	ľ	Maryland Prince George's	10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sh tified at once		10e Street and Number 9111 Linhurst Drive		10f. Zip Code 20735	1	0g. Citizen of What Cour	ntry?
ter death with ", or items 23 er must be no		3 Widowed 4 Divorced If Yes, Give Year	If Y∈	s Decedent of Hispanic Origes, specify Cuban, Mexican,  Yes 2 X No specify:		14. Race - Ameri White, etc. Specify: B1a	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers here are 72 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once TO Be Completed by Firnaral Director	a pajajdu	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  12th  College (1-4 or 5-	+) during mo	t's Usual Occupation (Give kost of working life. DO NOT o		Prince Geo	ndustry
e, MD 21215-0036  I and 2 should be filed within 77 Health and Mental Hygiens item 27 is marked other than r traumatic event, the Medical	e n	17. Father's Name (First, Middle, Last) Garry D. Crisp, I			s Name (First, Middle, Inet L. Than		
MD 21 d 2 should I lth and Mer n 27 is mar numatic ev	2 [	19a. Informant's Name/Relationship (Type, Print) Garry Crisp, I (Father)		Address (Street and Num Linhurst Driv			
Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition  1	Resurrect	ition (Name of cemetery, her place)  ion Cemetery ame and Address of Facility 633 Old Alexa	Lee Funers		Maryland
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the failure List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Due to (or as a consecutive condition)	he death. Do not enter th				Approximate Interva Between Onset and Death
recuted and -transit	Examille	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consected of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions, if any leading to the conditions, if any leading to the conditions of the conditions of the conditions of the condition of the c					
ou, ate be execu hysician anc e burial - tra		UNPENDED AMENDED					
the death certificate be ex the attending physician ched for use as the burial-		FEMALE: 23c. If yes, outcome   1	2 Fet	al death 3 Ectopic ner (Specify)	pregnancy	23d. Date of delivery Month E	Year Year
irres that the de n signed by the d be detached f	3	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Pai	1Yes	obacco use contribute to	ably 4 Unknown
w requires been as bear been as been as been as been as been as been as been as been a					24a Was autop perfo		topsy findings available completion of cause of
The law Tracate has page 2 s	5 _						s 2 No
VICAL RECORDS, rsician: The law requires is certificate has been sig director, page 2 should be	2 2	25. Was case referred to medical examiner?  Hospital: 1 Inpatien	t 2 ER/Outpatient	26.Place of Death (	Check only one)	Residence 6 V Other	
iending Physician: The lar eath or: After this certificate ha the funeral director, page 2		examiner? Hospital: 1 Inpatien  1 Ves 2 No  27. Manner of Death 1 Natural 5 Pending  Hospital: 1 Inpatien  28a. Date of Injun  (Month Day Yea  Oct 13, 2006		3 DOA Other	Check only one)  Nursing Home 5  28d. Describe	Residence 6 Other	
UNISION OF VITAL REC- pital or Attending Physician: The la pital or Attending Physician: The la reral Director: After this certificate he filled in by the funeral director, page 2 Certification: To Re Com-	Setulication. To be	examiner?  1	y 28b. Time of In 1748 hrs ury - At home, farm, stree	3 DOA Other DOWN	Check only one)  Nursing Home 5 28d Describe Subject was confirmed and c	Residence 6 Other how injury occurred s shot	: Scene
Division of Vital Recc o the Hospital or Attending Physician: The lar dithin 24 hours after death to othe Funeral Director: After this certificate ha ompletely filled in by the funeral director, page 2	cerunication. 10 be	examiner?  1	28b. Time of In 1748 hrs ury - At home, farm, stree al Street knowledge, death occurr	3 DOA Other 1 DOA other 2 DOA other 3 DOA Other 4 DOA other 3 DOA other 4 DOA	Check only one)  Nursing Home 5 28d. Describe Subject was  28f. Location (6 or Town, 8 6803 Dunnice, and due to the caus	Residence 6 Other how injury occurred s shot  Street and Number or Rustate) gan Drive, Clinton, se(s) and manner as start	Scene ral Route Number, City MD
\	cerunication. 10 be	examiner?  1	28b. Time of In 1748 hrs ury - At home, farm, stree al Street knowledge, death occurr	3 DOA Other 1 DOA other 2 DOA other 3 DOA Other 4 DOA other 3 DOA other 4 DOA	Check only one)  Nursing Home 5 28d. Describe Subject was  28f. Location (6 or Town, 8 6803 Dunnice, and due to the caus	Residence 6 Other how injury occurred s shot  Street and Number or Rustate) gan Drive, Clinton, se(s) and manner as start	ral Route Number, City MD ed e cause(s) nth, Day, Year)
Division of Vital  Division of Vital  bours after death meral Director: After this cert y filled in by the funeral director Certification: To Be	medical certification. To be	examiner?  1	y 28b. Time of In 1748 hrs  ary - At home, farm, street al Street  knowledge, death occurr ination and/or investigation and/or investigation at (Item 23a)	3 DOA Other 2 DOA njury 28c. Injury at Work? 1 Yes 2 v.t., factory, office building, etc. red at the time, date and platon, in my opinion, death occ. 29c. License number O.C.M.E.	Check only one)  Nursing Home 5  28d. Describe I Subject was  28f. Location (1 or Town, S 6803 Dunnit ce, and due to the caus curred at the time, date	Residence 6 Other how injury occurred s shot  Street and Number or Ruitate) gan Drive, Clinton, se(s) and manner as start and place, and due to the	ral Route Number, City MD ed e cause(s) nth, Day, Year)

			1- For Amend Item	23a per di	ryland 60, feb. Ce	718706 rtificate	of Dea	th and Nath	Mental Hy	giene () (	16	32988
	Dhunia		1. Decedent's Name (First, Middle, Last	)					2. Date of De	ath		3. Time of Death
4	Physic /Medi		Helen			Cra	yton		OCTO!	per 12	OO a	8:47am
1	Exami	ner	4a. Facility Name (If not institution, give	street and number)	1.1	4b. City, To	wn, or Local	tion of Death		4c. County	ol Death	
			5. Social Security Number 6. Se	reral Hos	spital	If Under 1	+1110	nder 24 Hrs.	Hy			
	Funeral Director			х Эм <b>2</b> ДГ г	(No yrs. last birthday, 91 Yrs.	Months [	Days Hou		8. Dale of Bir (Month, Da	y, Year)	9. Birthpla Countr	ice (State or Foreign
	-		Usual Residence of Decedent						09 0	5 15		WV
	death with the Maryland me 23a or 28a-f show Lmust be notified at		10a. State 10b. County		10c. City, Town or L	ocation					100	d. Inside City Limits
	e Ma	cto	MD NA		Baltimo	ore						1 ☐ Yes 2 ☐ No
	iff the	Dire	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of W	hat Countr	y?
	ath w	by Funeral Director	1905 North Fore				2120				S.A.	_
	er de item	une	11. Marital Status	12. Was Decedent Example Forces?		Was Deceden If Yes, specify	t of Hispanio Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black	- American	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X	No Spe	ecity:		Specify:	Bla	ck
21215-0036	within 72 hours after ene. then "nature!; or ite	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual C	Occupation			16b. Kind of Bus		
215	hin 7	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Give	kind of work of DO NOT use	done durina	most of work	ing	TOD. Naid Of Bus	siries symdu	stry
21	filed within Hygiene.	Completed	12th grade	College (1-4or 5+ na	' s	tock	Perso	on		Departm	nent	Store
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)							Maiden Surname	)	
yla	should be ind Mental imarked o	2	Jim White				I	da Ar	nette			
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Ty							er, City or Town, S		
	1 and Health em 27 ther tr		Viola Mason-Cou	sin				-		ve, F-1	., Ba	lto, Md
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	lemoval from State	20b. Place of Dispo cemetery, crei	sition (Name natory or othe	of er place)		Date	20c. Location - C	City or Tow	n, State
ţ	t. Pa ntmen ntent: njury		4 Donation 5 □ Other (Specify)		Mt. 2	ion		10/7	/06	Baltimo	re,	Md
Bal	permit. Pages 1 and Department of Health Importent: If item 27 any Injury or other tr 2008.		21. Similare Funeral Service Licens	1. XIMO	Wt 2	Name and A	F/H abasi	West n Ave	, Balt		Md	21215
			23a. Pa (1, Enter the disease, or compl. spock, or heart failure. List only or	catio s at caus to	ne death. Do not ent	er the mode o	f dying, such	h as cardiac	or respiratory ar	rest,	A	pproximate
	Physician		Immediate Cause (Final disease or condition	Cardi	ar Dr	^	pens	i 7				Inset and Death
1	/Medical Examiner		resulting in death)		consequence ol):		Ø.					
	Lammer		Sequentially list conditions,	)	owel obst	ruction	n and	necro	sis			
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	and and II-trar	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
8760,	cate be executed obysician and the burial-transit	alE		200 10 (01 00 0	30,000,000,000,000,000,000							
687	ficate phys	edical									-	
Вох	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy					23d. Date	ol dolivon	
ă	death e atte	Cla	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at tir		Ectopic pregr Other (specif				Mont	,	ay Year
0	tt the de by the tached	hys	9 Unknown	9□ Unknown								
S, P	es tha	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the un	nderlying caus	e given in Pa	art I.	23e. Did to	bacco use contrib	ute to the	cause of death?
Records,	v requir been s should	ompleted							1 🗆 Y	'es 2 □ No 3	Probab	y 4 (90nknown
ec	law nasb e2sl	pg							24a. Was a autop	an 24b. We	ere autopsy	/ lindings available letion of cause of
_		S							perfor	med? de	ath?	□ No
¥ita/	Physicisn: 1 this certificaral director, p	Be	25. Was case referred to medical examiner?	ospital:				lace of Death	Check only o	ne)		
	Phys	2	1 ☐ Yes 2 ☑ No ''  27. Manner of Death	1 Impatient						ence 6 Other		
o	ding After fune	E I	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury		Injury at Work?		28d. Describe h	ow injury occurred	i	
Division of	tor.	lical	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injune	- At home, larm, stre		1 ☐ Yes 2		201 1			
<u>S</u>	after Dire	Certification;	4 Homicide determined	building, etc.	(Specify)	et, lactory, on	lice		City or Tow	treet and Number n. State)	or Hural H	oute Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of r	tamination and/or inv	occurred at the	ne time, date	and place, a	and due to the c	ause(s) and mann	ner as state	ed.
	within 2 To the I complet	Mec	29b. Signature and title of certifier	and manner state	u		cense numb			9d. Date signed (		
	⊢ 3 ⊢ 8		Thomas	Honna	o Mn	0	950	3/1	1	/A_ I	S I	y, 19d/)
		-	30. Name and address of person who con	npleted cayse ol dear	th (Itam 23a) (Tuna 1	Oriet)	100	77		10-1-(	96	
			Thomas 1	31500. C	N.D.	-10 M	arila	MI	70n00	al Haci	10	
	Sta	te	31. Date filed (Month, Day, Year) OCT 1 8 2006	32. Registrar's	Signature	10 1 11	MAIN	Ju	ARIKI	N 1100	1100	
7.	Registra	ar	OCT 1 8 2006	A 352 18-1 .	S. Again	4	_					

			For State Registrar	State of Maryland / D	Department of H Certificate of L		ntal Hygien	2000	32989
	0		Decedent's Name (First, Middle, Last	)		2	Date of Death		3. Time of Death
	Physicia /Medic		Mary Angelina	Catina		0	Month 10,	2006	4:20 p <sup>M</sup>
}	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Death	4	c. County of Death	
			Maria Health Ca		Balti			altimor	
	Funeral		5. Social Security Number 6. Se	TM 257E	thday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign intry)
Н	Director		265-08-8576 Usual Residence of Decedent	87 87	115.	Ma.	y 4, 19	19 Ma	ryland
	land ow	Ì	10a. State 10b. County	10c. City, Towr	or Location				10d. Inside City Limits
	Many -f sh	to	MD Baltime	ore Balti	more				1 □ Yes 2 No
	r 28e	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	intry?
	th wit	aiD	6401 N. Charle	es Street	21212			USA	
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci an, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	
36	s within 72 hours after death with the Maryland piene. r then "neturel", or Items 23a or 28e-f show the Medical Evar it at most be rediffed at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite
21215-0036	turel'		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:	Decedent's Usual Occup	ation	16h	Kind of Business/	
5	in 72 "ne" r	olet	(Specify only highest grad	le completed)	(Give kind of work done of life. DO NOT use retired	durina most of working		Talle of Decirioses	nadot, y
212	i within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +	Teacher		Pa	rochia1	School
٦	be filed Ital Hygind of other event, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	First, Middle, Maide	n Sumame)	
/lar	should be and Mental marked o	10 E	Pasquele Catin	na		Dominica	Carpen	ti Cati	na
Maryland	0 0 0		19a. Informant's Name/Relationship (T	ype, Print) 19b.	. Mailing Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Z.	ip Code)
	1 and 2 Health tem 27 other tre		Bernice Feiling		401 N. Cha	arles St.			
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	comptan	Disposition (Name of y, crematory or other place	(9)		Location - City or 1	own, State
ţ	tment tent:		* 4 ☐ Donation 5 ☐ Other (Specify,		Maria Ceme	Control of the Contro	13/06	Glen Ar	m, MD
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens	Venak-	22. Name and Addres		d 6500	York F	Rd
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do r					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	cerebra	e Hemo	Muge			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of					O
п	CXammer		Sequentially list randitions	b					
	B 14 2	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	or):				
	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	c.  Due to (or as a consequence of	of):				
8760,	be e	ie H							
687	ficate p physics the	edicai		0.					
Вох	eath certific attending pl	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 <b>-</b>			23d. Date of deli-	very
Ď	death e atte	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	·		Month	Day Year
P.0	to the de by the a	hys	9 Unknown	9□ Unknown					
	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by P	Part II. Other significant conditions co	entributing to death but not resulting in		en in Part I.		_	the cause of death?
ord	w requir been si should	ompleted	(aumicau)	arifico gorar			1 Yes	No 3□ Pro	obably 4 □Unknown
ec	aw as b	nple	atrial fi	quenus			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
E H		Con	U				performed? 1 ☐ Yes 2√ N	death?	2 No
Vital Records,	Physicien: This certifical	Be	25. Was case referred to medical examiner?	Hospital:	trationt 20 DOA Cth	26. Place of Death (			
of	Phys this al dii	T.	1 ☐ Yes 2 ▼No  27. Manner of Death	I Inpatient 2 Ervou	itpatient 3 DOA 28c. Injur	Nuising Home	5 Residence d. Describe how inj		ify)
	D te	tion	1 Natural 5 Pending		njury Wor	k? Yes 2 □ No	a. 20001100 11011 111	a., 000a0	
Division	ten leat tor: the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa			f. Location (Street a		ral Route Number,
	after after Dire	Certification;	4  Homicide	building, etc. (Specify)			City or Town, Sta	te)	
		0	29a. Certifier XX Certifying Phy	reician. To the hest of my knowledge	death occurred at the tin	ne, date and place, and	d due to the cause(	s) and manner as	stated.
	Hospitel or 24 hours afte Funerel Dir stely filled in l	dical	(Check only 2 Medical Exam	iner: On the basis of examination and	d/or investigation, in my o	pinion, death occurred	at the thine, date at		to the cause(s)
	o the Hospitel vithin 24 hours o the Funerel ompletely filled	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	d/or investigation, in my o			ate signed (Month	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		(Check only 2 Medical Exam	iner: On the basis of examination and	d/or investigation, in my o			ate signed (Month	
	To the Hospite within 24 hours To the Funere completely fille		(Check only 2 Medical Exam	on the basis of examination and and manner stated.	d/or investigation, in my o	e number		ate signed (Month	, Day, Year)
	To the Hospite within 24 hours To the Funere completely fille		29b. Signature and title of certifier  29b. Name 1 ddress of person who of	ompleted cause of death (Item a)	d/or investigation, in my o	e number	29d. D	ate signed (Month	, Day, Year)
	To the Hospite within 24 hours To the Funere To the Funere completely fille	ĭte	29b. Signature and title of certifier  29b. Name 1 ddress of person who of	ompleted cause of death (Item 2a)	29c. Licens 29c. Print) Crype, Print)	e number	29d. D	ate signed (Month	, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 006 32990 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:40 p RUTHANNOct 12, 2006 COOPER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Millennium Health of Liberty Heights If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min. 1 □ M 2 □ F Director 214-64-0062 W.Va Sep 21, 1913 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Mudical Examiner must be notified at Director Baltimore 1 Yes 2 □ No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6208 Hilltop Avenue 21206 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other then "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify. þ Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Hemshire Samuel Tibbs 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health 6802 Hilltop Avenue Baltimore, Maryland 21206 Katherine Sharpe Daughter othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 10/14/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. permit. 21. Signalus of Funeral Service Livers 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myccordina Immediate Cause (Final disease or condition resulting in death) Propoble Physician /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) P.O. the Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Peripheral Vascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 No Division of Vital 1 🗌 Yes 2 No 1 TYes tha Hospital or Attanding Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After th funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner-of Death 28b. Time of 28d. Describe how injury occurred Injury s after de. ••I Director: Atte 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To tha Funaral Direcompletely filled in b 4 Homicide 29a. Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and titla of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0062634 MO 13/06 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10802 HICKURY RIDGE RUAD COLUMBIA IGEN AWAN 31. Date filed (Month, Day, Year) 52. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien [ ] 1 32991 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 2006 Collins George Howard 1:05a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Continuum Care At Sykesville Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 2 1930 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Director 220-26-0616 76 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heelth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location if Heelth and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director Md Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Gibbons Road 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1√ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Md. Department Of Elementary/Secondary (0-12) College (1-4or 5+) Warden Corrections +6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard M. Collins Gladys Irene Chase 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel S. Collins (wife) 911 Gibbons Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10-21-06 20c. Location - City or Town, State Department of H Important: if ite any injury or ot once. XBurial 2 ☐ Cremation 3 ☐ Removal from State Eldersburg, MD Johnsville UMC Cemetery 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Pargrofarge erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner h hagna Sequentially list conditions, if a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events g physicien and Examiner uence of) or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use es the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death signed by the el 5 Other (specify) 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has 1 Yes 2 No within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of D th Check only one 1 ☐ Yes 2 No Hospital: Other: 4 1 I rsing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) MU -0054218 10-17-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcolm dune Westminster MD 21157 KAMERTA PAMAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

			1 - State Ce	ertificate of Death	2000 32992											
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Mark Bradley Cooper	2. Date of Death Month	Day Year 3. Time of Death											
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	16 2006 1,03 /1 M											
	Exami		11480 Old Frederick Road	12	Howard											
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-68-5740 1 M 2 F 47 Yrs.		9. Birthplace (State or Foreign Country)											
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits											
	e Mar	ctor	Md Howard Marriot	ctsville	1 ☐ Yes 2 🛣 No											
	death with the Maryland rme 23a or 28a-f ehow rust be notified at	Funeral Director	10e. Street and Number 11480 Old Frederick Road		Citizen of What Country?											
	ne 23	eral			JSA  14. Race - American Indian.											
21215-0036	ours after of the or item	þ	Armed Forces? 1 □ Never Married 2 □ X Married 1 □ Yes 2 1 □ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ XNo Specify:	Black, White, etc.  Specify: white											
2-0	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	. Kind of Business/Industry											
12	within Bne. then '	dmo	Elementary/Secondary (U-12)   College (1-4or 5+)	DO NOT use retired) Lesel mechanic	diesel											
<u>5</u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid												
/lan	uld be Vienta Irrked	ToB	Martin K. Cooper	June Catherine Ma	rtin											
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Expinition outside indiffied at ADES.	1 5		ing Address (Street and Number or Rural Route Number, Ci ) Old Frederick Rd., Marriot												
				matory or other place)	Location - City or Town, State											
Balt	permit. Departnimporte any injt.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Haight Funer P.O. Box 195 Sykesville, MD	al Home & Chapel											
	Physician postuled with provided and provide	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Artery Disease	Approximate Interval Between Onset and Death											
O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	by Physician/Me	by Physician/Me	by Physician/Me	hysician/Med	hysician/Med	hysician/Med	hysician/Med	hysician/Med	hysician/Med	hysician/Med	hysician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ds, P	uires that signed to d be deta					Part II. Other significant conditions contributing to death-but not resulting in the un	DICOREO	o use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Unknown								
ecords,	law requir as been si 2 should t	olete	Hyper tension	24a. Was an	24b. Were autopsy findings available											
		e Completed	25. Was case referred to medical	autopsy performed 1 ☐ Yes 2 <b>€</b> /	prior to completion of cause of death?											
	Physician: this certifice al director, p	ToB	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only one)  ont 3 □ DOA Other: 4 □ Nursing Home 5 ☑ Residence	6 □Other (Specify)											
Division of	Attending Physician: r death. ector: After this certifice by the funeral director,		27. Manner of Death  1													
Sio	r Attending er death. rector: After by the funer	cat	2 Accident investigation	M 1 Yes 2 No												
2	5 # 5 S	Certification;	4 Homicide determined determined building, etc. (Specify)	eet, factory, office 281. Location (Street City or Town, St.	and Number or Rural Route Number, ate)											
		U	29a. Certifier  1. Certifying Physician: To the best of my knowledge, death		(c) and magger on elected											
	e Hospitei or 124 hours aft e Funerai Di letely filled in		(Check only one)  2 Medical Examiner: On the basis of examination and/or invalid	recurred at the time, date and place, and due to the cause vestigation, in my opinion, death occurred at the time, date a	and place, and due to the cause(s)											
	he Hosp n 24 hou he Funer pletely fill	Medical	(Check on) 2 medical Examiner: On the basis of examination and/or inv	vestigation, in my opinion, death occurred at the time, date a	Oate signed (Month, Day, Year)											
•	To the Hospite within 24 hours To the Funeral completely filled	edical	one) and manner stated.	vestigation, in my opinion, death occurred at the time, date a	ind place, and due to the cause(s)											
•	To the Hospite within 24 hours To the Funeral completely filled	edical	one) and manner stated.	vestigation, in my opinion, death occurred at the time, date a	ind place, and due to the cause(s)											
	To the Hospite Within Z4 hours within Z4 hours Side Sunder Completely filled Completely filled to the Complete Side Side Side Side Side Side Side Sid	Medical	29b. Signature and title of certifier  29b. Signature and title of certifier	vestigation, in my opinion, death occurred at the time, date a	ind place, and due to the cause(s)											

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** October 15, Luisa M. Cruz 2006 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9749 Gudel Drive Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEP 3, 1911 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□M 2XF 95 Yrs. Director 056-18-7691 Puerto Rico Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Ellicott City Marvland Howard the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 9749 Gudel Drive 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 end 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Inhoparant: if Item 27 is marked other than "naturel," or Item eny injury or other treumatic event, the Medical Features Black, White, etc. 1 Never Married 2 Married Puerto Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Hispanic δ 3 X Widowed 4 ☐ Divorced Rican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 Pre-School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcello Suarez Brigetta Morrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9749 Gudel Drive Ralph Cruz/Son Ellicott City, MD 21042 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/16/06 Baltimore, MD 21. Signature of Funeral Service bicensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Frederick Road Baltime

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit The law requires that the death certificete be executed Box 68760 Physician/Medical use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy jo Month Day Year P.O. I detached 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 10 1 ☐ Yes 2 No 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After in 24 hours after death.
the Funerel Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signarur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Golle, M.D., 8186 Lark Brown Road, Suite 301, Elkridge, MD Gloria D. 21075 32 'Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

O = 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	394
Record   As   Colly   As   Colly   C	
Funeral Director    Security hymney   15   15   15   15   15   15   15   1	M
Director    Director	ty
10s. State   10b. County   10s. State   10b. County   10s. Street and Number   10s. Street and N	Foreign
By Appropriate and Company and	
By Appropriate and Company and	
By Appropriate and Company and	
By Appropriate and Company and	
23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bah Onset and Conset (Final disease or condition resulting in death)  Physician / Medical Examiner  Physician / Medical Exam	
23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bah Onset and Conset (Final disease or condition resulting in death)  Physician / Medical Examiner  Physician / Medical Exam	
23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bah Onset and Conset (Final disease or condition resulting in death)  Physician / Medical Examiner  Physician / Medical Exam	ilem
Sequentially list condition resulting in death)  Sequentially list conditions of any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Due to (or as a consequence of):  Due to (or a	140174
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):   Due to (or as a consequence of):	veen
d.	own
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of death of the cause of death of the cause of death of the cause of	ear
O to a leg leg leg leg leg leg leg leg leg leg	
## F = 0 atrial fibrillation   performed?   death?	vailable iuse of
The second of th	
Hospital: 1 A Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
25. Was case referred to medical examiner?  1	
1 Inpatient 2 ER/Outpatient 3 DOA Survival Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Month, Day Year)  28a. Date of Injury	7B7,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (29c. License number)  29c. License number (29c. Date signed (Month. Day, Year))	
29b. Signature and title of certifier  P20876  29c. License number  P20876  29d. Date signed (Month, Day, Year)	
30. Name and address of person who come red cause of death (Item 23a) (Type, Print)	
State Registrar  OCT 1 8 2006  State Registrar	

			1 - For State Registrer			Depa		Health and M f Death	Mental Hyg	gien 200	32995
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea		3. Time of Death
_	Physici		Doran	James	Dowe1	1			October	Day Ye	LA
72	/Medic Examir		4a. Facility Name (If not institution, give		DONCI		4b. City, Town,	or Location of Death		4c. County of D	
	LAGIIII	ici	112 West Third S								
	C		5. Social Security Number 6. S		e (In yrs. last	birthday)	If Under 1 Yea	ederick Ir   If Under 24 Hrs.	8. Date of Birth		erick Birtholace (State of Foreign
	Funeral Director			XM 2□F	81	Yrs.	Months Day		(Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		01				FEB 14,	1925 I	llinois
	land		10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	Aary	ŏ					Essa	J 1 - 1 -			1 ☐ Yes 2 🛣 No
	he h	ect	Maryland Frederi	ck				derick			
	di pi	5	10e. Street and Number				10f. Zip Code			10g. Citizen of What	t Country?
	within 72 hours after death with the Maryland ane. than "naturel", or items 23e or 28e-f ehow in Marical Exemple regaller collined at	by Funeral Director	112 West Third S	T				21701		USA	
	ep E	Ine	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
9	afte or i	F	1 Never Married 2 Marned	1 XYes 2 ☐ I If Yes, Give	No		1 ☐ Yes 2 🔯 N			Specify:	
8	ours	Q P	3 Widowed 4 Divorced	Year or Dates:	1943-50	)	X			орволу.	White
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16	Sa. Dece	dent's Usual Occ	upation e during most of work	kina	16b. Kind of Busine	ess/Industry
2	Par B	gi	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retii	red)	9		
21	E C C	Ö		4		_Cor	itractor			Ceram	ic Tile
	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>a</u>	Mental Mental arked o	To	Vernon Dowell					Vio	olet Dit	to	
Maryland	and N		19a. Informant's Name/Relationship (	Type, Print)	1	9b. Mailir	ng Address (Stree	et and Number or Rui	ral Route Number	r, City or Town, Star	te, Zip Code)
ž	and 2 ealth a m 27 te		Eleanor V. Dowell	/Wife		112	West Th	ird Street	Fredor	iok MD	21.701
a,	s 1 and 2 of Health Item 27 other tr		20a. Method of Disposition	.,	20b. Place	of Dispo	sition (Name of			20c. Location - City	
٥	nt of		1 ☐ Burial 2 X Cremation 3 ☐				natory or other p	1			
Ë	rtant rtant		4 Donation 5 Other (Specific		Metro	cre	matory,	Inc. 10/1	7/06	Baltimo	re, MD
Baltimore	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natun eny injury or other traumatic avent, its Madical QDGs.		21. Signature of Funeral Service Licer	youll	•	22	. Name and Add	ress of Facility Cr	remation	Society	of MD, Inc.
	40 % e 0		Edward A Gr	egorchik				derick Roa			21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	I the death. D	o not ent	er the mode of dy	ying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/				CARCIA			Onset and Death
	/Medical		resulting in death)	Due to (or as			C. C. C.		30		
	Examiner		A CONTRACTOR OF THE STATE OF TH								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	e of):					
/	be executed sicien and burial-transit	Examiner	Cause (Disease or injury								
<u>,</u>	exec n an	Exa	resulting in death) Last	Due to (or as	a consequenc	e of):					
760,	icate be ex physicien s the buria	call		4							
189	phys phys s the			d	-						
×	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					O2d Date of	dalian.
Вох	atten for u	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnan	су		23d. Date of Month	Day Year
	the de	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time or death	3	Other (specify)				
P.0	that the de ned by the s detached t	F.	-	antichutian ta dooth b	ut mat consisting	- in the		man in Book t	22a Didas		
0 % 5 B   Q						idenying cause g	given in Part I.		obacco use contribute to the cause of death?		
Š	w require been si should I	ted							1 U Y	es 2□No 3□	Probably 4 Minknown
ပ္ထ	e lawr has be 192 sh	Completed							24a. Was a		autopsy findings available to completion of cause of
Œ	The The page	E							perfor	med? death	
Vital		C	25. Was case referred to medical					26. Place of Deal			165 21110
5	Physicien: r this certificatel director,	CO	examiner? 1 ☐ Yes 2 € No	Hospital:	nt 2□ER/0	Outantion	2000	thos	,		
ō	Phys rthis ral di	-: T	27. Manger of Death	28a. Date of Inju		. Time of				ence 6 Other (5	specify)
	Attending I r death. ector: After by the funer	Ö	1 Matural 5 ☐ Pending	(Month, Da)	Year)	Injury	W	ork? □Yes 2□No		,,	
S	tor: the	cal	2 Accident investigation 3 Suicide 6 Could not be		***	<b>6</b>			000 1 100	14/	0.10
Division	fter oliver	Certification;	4 ☐ Homicide determined	28e. Place of Inju	c. (Specify)	rarm, str	eet, factory, office	9	City or Town		r Rural Route Number,
	urs a	ပိ									
	Hosp 4 hos rune ely fi	ca	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	of my knowled examination	lge, death and/or inv	occurred at the restigation, in my	time, date and place, opinion, death occur	and due to the cared at the time. d	ause(s) and manne	r as stated. due to the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	onej	and manner sta	ited.						
	To To	2	29b. Signature and title of certifier		4 -			nse number	2	9d. Date signed (M	onth, Day, Year)
			( Drul	~	MD		02	21936		October 1	7. 2006
-	nn		30. Name and address of person who	completed cause of d	eath (Item 23a	а) (Туре,	D.C. A				
	y		A. DONEL	son mo	, 65	50	THoma	& MOHNE	ON DC.	FREDER	(CK 21702
		te	31. Date filed (Month, Day, Year)	3 Registra	ar's Signature	A	AP .				

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygien P O C

			1 - For State Registrar	State of IVI	aryland /	Cer	ırımeni <i>tificate</i>	or He	eaith and Death	Mental H	ygien Reg. N		16	32996															
ı	Physici /Medi		1. Decedent's Name <i>(First, Middle, L</i> Patricia		Fischer	r				2. Date of D Octob	eath		Year O	3. Time of Death 10:45 A M															
	Examir		4a. Facility Name (If not institution, g	ive street and number)	11				ocation of Dea			c. County		<u> </u>															
	Funeral Director		Future Care 5. Social Security Number 6. 214-50-3501	Sex 7. Ag	11age e (In yrs. last i 2	birthday) Yrs.	If Under	1 Year Days	IOTE If Under 24 Hrs Hours Min		irth ay, Yea	n/a		place (State or Foreign http:/ Tand															
	ס		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation			Jail. 4	, 15	754		Od. Inside City Limits															
	Maryl	tor	Maryland n/a		Balt									1 X Yes 2 □ No															
	th with the 23a or 28i	ai Direc	10e. Street and Number  7 South Monasters	y Ave.			10f. Zip (		.229			itizen of W		-															
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 le marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y			Vas Decede Yes, speci		panic Origin? (! , Mexican, Puel Specify:	Specify Yes or N nto Rican, etc.)	0-		k, White,	an Indian, etc. White															
2-0	72 hou	eted	15. Decedent's E (Specify only highest gi	Education rade completed)	16	a. Deced	ent's Usual	Occupat	ion ring most of wo	orkina	16b.	Kind of Bu	siness/Inc																
Baltimore, Maryland 21215-0036	d within giene. ir then '	Completed	Elementary/Secondary (0-12)	3 years	)+)		onoruse sion (			g	Но	spita	al																
	be file of othe event,	Be	17. Father's Name (First, Middle, Las Francis M. Moran	t)				1		me (First, Middle a O'Neil	, Maide	n Sumame	9)																
	should nd Mer mark	으	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailine	Address (	Street an		ural Route Numb	er. City	or Town	State Zin	Code															
	and 2 ealth a m 27 le		Veronica M. Hanne		hter)	440 I	owell	L St.	Manche				5.ta10, 2.p	0000/															
	ages 1 ant of H it: If ite y or oth		20a. Method of Disposition 1 ☐ MBurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place cemet					Date		ocation - (																	
altir	apartme aportan ay injur		21. Ingrature of Funeral Service Lice	ensee			Name and			18-2006 Funeral		timo:		עוו															
_	20E#3			. Wayne Ost		23	37 E.F	atar	sco Ave	e. Balti	more	, mD	2122																
	Physician /Medical	2 4	2. Part1. Enter the disease, or conshock, or he of failure. List only immediate the final disease or condition resulting in death)	a. End	stage	line	8	or aying,		c or respiratory a	irrest,			Approximate Interval Between Onset and Death															
1	Examiner		Sequentially list conditions	b. Due to (or as a	(or as a consiquence ot):									year															
	pet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).								Year																	
Ö,	cate be executed physicien end the burial-transit		that initiated events resulting in death) Last	c. Due to (or a se	nsequence								+																
68760,	tificate b ng physic as the bi	Aedical		_ d.		-	-	_					-																
	death cei	hysician//	ysician/M	iysician/M	ysician/M	ıysician/M	iysician/M	nysician/M	ysician/M	nysician/M	nysician/M	nysician/M	hysician/M	hysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. It yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic prec Other (spec					23d. Date Mont		ry Day Year			
1	as t		Part II. Other significant conditions	contributing to death bu	it not resulting	in the und	derlying cau	ıse given	in Part I.	23e. Did 1	obacco	use contrit	oute to the	e cause of death?															
ecords,	> 4	eted								-		□No 3		. 9															
r,	The la ate has page 2	O	O	O	O		O	O	O	O	O	ပ	O	O	O	O	C	25. Was case reterred to medical							1 Yes	osy ormed? 2 No	- ae	atn?	sy tindings available apletion of cause of
	Di 00 🛣	To Be	examiner?	Hospital:	nt 2 🗆 ER/O	utpatient	3□ DOA	Other		ath <i>(Check only o</i> Iome 5 ☐ Resi		6 TOther	(Specify)																
on of	ding h. After fune				27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	Year) 28b.	Time of Injury	280 M	Work?		28d. Describe																	
DIVISION	spitel or Attending Fours after death. erel Director: After filled in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office 28t. Locati							28t. Location (. City or To	ation (Street and Number or Rural Route Number, or Town, State)																		
	To the Hospitel of within 24 hours af to the Funerel D completely filled in	edical	29a. Certifier Certifying Pt (Check only one)	hysician: To the best o miner: On the basis of and manner stat	examination a	e, death ond/or inve	occurred at estigation, in	the time, my opin	date and place ion, death occu	, and due to the rred at the time,	cause(s date and	and mani	ner as sta	ited. the cause(s)															
	within comple	Me	29b. Signature and title of certiler	)				License n	umber		29d. Da	te signed	Month, D	lav. Year)															
. 1				Than Porn, 1					D 5108	8.	Detel	ser	1610	2006.															
4			30. Name and address of person who	ion ST. Pan	I Plau	L,	# 701	١,	Bentin	nou, mi	2	202	_																
	Stat Registra		31. Date filed (Month, Day, Year) OCT 1 8 20	32. Hegistra	r's Signature	Los	2600																						

State of Maryland / Department of Health and Mental Hygien 2005 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death LUDELIN M. **Physician** GARDNER Day Year Xtober ZOOC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LEVINDALE GERIATRIC CENTER BALTIMORE CITY N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 06/03/1922 **Funeral** 9. Birthplace (State or Foreign 1 M 200 215-41-8819 84 Director JAMAICA Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. fnside City Limits 28a-f show other traumatic event, the Mudical Examiner must be notified at N/A BALTIMORE CITY MD Director 1X Yes 2 □ No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 2, any injury or other traumatic event, the Medical Exercises. 10f Zin Code 10g. Citizen of What Country? 21215 USA 4212 FORDS LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify: BLACK þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry n. DO NOT use retired) HOUSEWIFE Elementary/Secondary (0-12) Colfege (1-4or 5+) DOMESTIC 6ТН 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) MOLVIAN JOHNSON Be JAMES JOHNSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORA FRAY / DAUGHTER 4212 FORDS LANE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of Carnetery, crematory or other place)
PEAL RIVER
CHURCH YARD 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State PEAL RIVER, 10/28/06 4 ☐ Donation 5 ☐ Other (Specify) HANOVER, JAMAICA 21. Signatu HOWELL FUNERAL HOME 21207 HEIGHTS AVE, BALTIMORE, M 22. Name and Address of Facility 4600 LIBERTY V. Enter the disease, or complications that cly, or heart affire. List only one cause or the dead. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate fnterval Between Onset and Death negiate Cause (Finat **Physician** seese or condition /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any lacking to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 100 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 2/2/10 certificate 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: ို 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this d in by the funeral 27. Manner of Death 1 Natural 2 [] Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No within 24 hours after design to the Funeral Directo completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygien 2005 32998 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Leland Gavin, Sr. October 12 2006 **Physician** James 19:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner North Arundel Glen Burnie Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 21, 1925 Birthplace (State or Foreign Country) **Funeral** Hours Days 1₩ 2□F 217-26-2152 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7054 Cresthaven Drive 21061 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No IfYes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Cajun δ WW II Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) Police Officer 12 years n/a Anne Arundel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas Gavin Gertrude Tuttle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health i Eileen Gavin (wife) 7054 Cresthaven Dr. Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 10-17, 2006 Glen Burnie, Maryland 21. Signature of Francis Survice Lice McCully-Polyniak Funeral Home, P.A. J. Wayne Osterling 3204 Mountain Road Pasadena, Maryland 21122 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, why one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NonSmell **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 12 No 24a. Was an 1 Yes 2 No of Vital ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Monument | 4 Nursing Home | 5 | Residence | 6 | Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 ⊠Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-1-0251 October 13,2006 grung 30. Name and address of person who compiled cause of death (Item 23a) (Type, Print) 325 HOSPITAL DRIVE SINTE 208 OCH ANEY JUEN BURNIE, MJ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2006

			1 - For State Registrar		d / Depa	artment of Hertificate of E	ealth and Death	F	Reg. No.	32999
pains.	Physici /Medi		1. Decedent's Name (First, Middle, Last)  MARGARE	=T	GG	FF		2. Date of Dea Month	Day	Year J=55 AM
	Examir	ner	4a. Facility Name (If not institution, give s Glen Burnie Heal	th & Rehab.		4b. City, Town, or Glen Bu		ath	4c. County Anne	of Death Arundel
	Funeral Director		230 42 0934	7. Age (In yrs. ) 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1929	9. Birthplece (State or Foreign Country) West Virginia
Baitimore, Maryland 21215-0036  sernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Aaryland	٥	Usuel Residence of Decedent  10a. State 10b. County  Maryland N/A		y, Town or Lo Baltimo					10d. Inside City Limits 1 Yes 2 □ No
	with the N a or 28a- the notifi	Director	10e. Street and Number			10f. Zip Code 212:	25	I0g. Citizen of W		
	be filed within 72 hours after death with the Marylan tall typiene.  d other than "natural", or items 23s or 28s-f show event, the Madical Examinar must be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 🔀 Married	12. Was Decedent Ever in U. Armed Forces? 1  Yes, 2 No If Yes, Give Year or Dates:	l:	Vas Decedent of His i Yes, specify Cuban	panic Origin? , Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race Blace	e-American Indian, k, White, etc. White
	hin 72 hours e. an "natural" Medical Ex	pleted b	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)	cation	16a. Deced (Give	ent's Usual Occupat kind of work done du DO NOT use retired)	ion	vorking	16b. Kind of Bu	
	tygi a	Be	10th 17. Father's Name (First, Middle, Last)	. Burford	Cler			ame (First, Middle,		Security Adm.
	of Health and Mental Fitter 27 fe marked our rother traumatic ever	70	19a. Informant's Name/Relationship (Type Roland Goff / Hus	рө, Print)		g Address <i>(Street ar</i> Everett S	nd Number or I	Rural Route Number		State, Zip Code) 1and 21225
more,	Pages 1 a lent of Hez nt: if item ry or othe		20a. Method of Disposition  1 □ Burial 2 □XCremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	JINGVALITOITI GLALO		sition (Name of natory or other place, Crematory				City or Town, State
Palt Palt	permit. Pages to Department of Himportant: If ite any fnjury or ot once.		21. Signature of Funeral Service License		22.	Name and Address	of Facility	Gonce Fun	eral Se	rvice, P.A. Maryland 21225
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Facture Due to (or as a consequ	u p	Thyive		ac or respiratory arr	est,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
00/00	ificete be physicie ss the bur	dicai	d.							
requires that the death cert	W fequires that the death certificele be executed been signed by the ettending physicien and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
	quires that en signed t	by	Part II. Other significant conditions cont	inbuting to death but not resu	lting in the un	derlying cause given	in Part I.			bute to the cause of death?  3   Probably 4   Unknown
	cate has be page 2 sho	Completed	- Hyperteesin	)				24a. Was a autops perform	y pr ned? de	ere autopsy findings available for to completion of cause of sath?  Yes 2 No
. vital	ysician is certifi director	To Be	25. Was case referred to medicat examiner?  1 Tes 2 No Ho	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	0.00		eath <i>Ch</i> eck only on		(Specify)
nding Phy	or the notation of page of the day within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 ĀNatural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury a Work?		28d. Describe ho		
DIVIS	rs after de at Direct led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number , State)	r or Rural Route Number,
	the Funer the Funer pletely fil	ledicai	one)	cian: To the best of my know er: On the basis of examinati and manner stated.	on and/or inve	estigation, in my opir	nion, death occ	a, and due to the ca curred at the time, da	iuse(s) and man ite and place, ar	not as stated. nd due to the cause(s)
)	\$ 7 kg	Σ	29b. Signature and title of certifier	- CMT	-	29c. License r	12 S S I	d Drive	od. Date signed	(Month, Day, Year) 16,200 6
	'b		30. Name and address of person who com	npleted cause of death (Item	23а) (Туре, Р	(rint) 325 P	Cospita	1 Drive	Suite	208
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ле Даск	The B			8	

06-07441 Frazer Grout

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1	i- For State Registrar	Certificate	of Death		Re	eg. No. 20	06 3300
Physicia Medical Examin	-	1. Decedent's Name (First, Middle,Last)  Frazer G	rout			2. Date of Deat Month October 2	Day Year	3. Time of Death 2351 hrs
San Contract of the Contract o		4a. Facility Name (if not institution, give street and number)	1040	4b. City, Town, or	Location of Dea		4c. County of Dea	
<b>-</b>		University of Maryland Medical Center  5. Social Security Number 6. Sex 7. Age (1)	n yrs. last birthday)	Baltimore  If Under 1 Yes	ar If Under 24H	Irs 8 Date of Bir	N/.	
Funeral Director		UNK 1 M 2 F		Months Day		in.	Fore	
<b>x</b>	ļ	Usual Residence of Decedent	c. City, Town or Loc	ention			7, 17041	10d. Inside City Limits
d how any	_		c. Gity, Town or Loc	Baltimo				1 X Yes 2 No
ne Maryland or 28a-f show ffed at once	Director	Maryland N/A  10e. Street and Number		10f. Zip Code	re	1	0g. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once		1144 S. Hanover Street			21230		United Ki	
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f she. Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	1 1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	White, etc.	erican Indian, Black,
after d	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1	Yes 2 X No			Specify:	White
2 hours "natur	ted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)		lent's Usual Occupa most of working life			16b. Kind of Busines	s/Industry
1215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "natural" event, the Medical Examine.	Completed	12		Chef				aurant
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ceevent, the Medics	Be Co	17. Father's Name (First, Middle, Last)  Ronald Grout				me (First, Middle, I zabeth Je	,	
	일	19a. Informant's Name/Relationship (Type, Print )	19b. <b>M</b> ail	ling Address (Stre	et and Number o	r Rural Route Nun	nber, City or Town, Sta	ate, Zip Code DL94PE
e, MD and 2 sho Health and item 27 is		Elizabeth Sidaway/Mother  20a. Method of Disposition	Cher	ry Tree (	Cottage	Colburn Date	Village, N	V. Yorkshire
Baltimore, MD 2 permit, Pages I and 2 shoul Department of Health and N Important: If item 27 is in injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State	crematory or		,,		Baltimor	
Baltimore permit, Pages I Department of I Important: If injury or other	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee					Society of	
		Thomas Gregor 23a. Part I. Enter the disease, or complications that caused the	السسب	299 Fred	erick Ro	oad Balt	imore. MD	21228 Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Dilated Cardiomy)		. and mode of aying	,, 000,, 00 00, 0, 0, 0, 0, 0, 0, 0, 0,	,,,		Between Onset and Death
Examiner	İ	or condition resulting in death)  Due to (or as a consequ	<u> </u>					
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of the conditions).	uence of):		<del>_ ,, ,</del>			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):								
760, ciate be executed physician and the burial - transit		d						
60, ate be e hysician e burial	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of deliv	ery
Box 68760, c. death certificate be the attending physicical for use as the burind for us		23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic preg	gnancy	Month	Day Year
Box te death the atte	Physician	1 Yes 2 No 9 Unknown 9 Unknown		Other (Specify)				
P.O.		Part II. Other significant conditions contributing to death b	ut not resulting in th	e underlying cause	given in Part 1.			to the cause of death?  robably 4 V Unknown
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the fuspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed by		• •			24a. Was		autopsy findings available o completion of cause of
Reco	omo						rmed? death	?
Vital Rec ysician: The his certificate	Be C	25. Was case referred to medical examiner?  1 Ves 2 No	0 FD/0 1		of Death (Chec		Decidence C O	-
n of Vi ding Physi After this funeral di	<u>ا</u> ي	1 ✓ Yes 2 No Inpatient  27. Manner of Death  28a. Date of Injury (Month, Day, Year	28b. Time	hormon	ury at Work?	28d. Describe	Residence 6 Ot how injury occurred	ner:
tendin death. rtor: A	atior	Natural 5 Pending  Accident Investigation			Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law require ours after death.  reral Director: After this certificate has been sifilled in by the funeral director, page 2 should be	Certification:	Suicide Could not be determined (Specific)	y - At home, farm, s	treet, factory, office	building, etc.	28f. Location ( or Town, S		Rural Route Number, City
Hospit 24 hour Funer:		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death oc	curred at the time, o	date and place, a	and due to the caus	se(s) and manner as s	tarted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.  29b. Signature and title of certifier	nation and/or investi		n, death occurre	d at the time, date	and place, and due to	
		(And de Hall	an		.M.E.		October 4, 200	
1		30. Name and address of person who completed cause of dea				-		
d		Carol Allan, MD Assistant Medical Examin 31. Date filed (Month, Day Year) 32. Registrar's		n Street, Baltin	nore, MD 212	201		
Sta Registi	ne.	31. Date filed (Month, Day Year) 8 2006 32. Registrar's	Gas As					